NORTH TEXAS UROLOGY

PATIENT REGISTRATION SHEET

Please print: **Date:** _____

Patient Name_____SSN# _____

Home Address _____Apt #_____

City _____State_____ Zip_____ Marital Status_____ DOB _____

Email_____

Phone: Home _____ Work _____Cell _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

How did you hear about our office? _____

PATIENT EMPLOYER INFORMATION

Employer name _____ Phone _____

Employer's street address _____

City _____ State _____ Zip _____ Employment Status: PT FT

INSURED PERSON (IF NOT PATIENT)

Name _____ SSN# _____

Date of birth _____Street address _____

City _____State _____ Zip _____

SPOUSE INFORMATION

Spouse's Name _____ Date of birth _____

Spouse's employer _____Street address _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

EMERGENCY CONTACT

Name of contact _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

PHARMACY

Pharmacy and location _____Pharmacy Tel# _____

NORTH TEXAS UROLOGY

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AUTHORIZATION FOR RELEASE OF INFORMATION

_____
(Date)

I _____ give my permission for North Texas Urology
(Patient Name)

Physicians and/or the staff to discuss my medical treatment, account information and/or labs with the following <u>family members and/or friends</u>:

<u>Individuals Name</u>	**<u>Relationship</u>**	**<u>Phone Number</u>**

_____ _____
(Signature of Patient or Responsible Party) **(Patient Date of Birth)**

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INFORMATION AND ASSIGNMENT OF BENEFITS

I understand that the patient co-payment/deductible responsibilities are to be paid at the time of service and that all charges are my responsibility whether or not they are paid by insurance. If I have Medicare or belong to an HMO, POS, MC, or PPO the terms of the doctor's contract with the network will govern payment policies.

I hereby authorize the physicians of North Texas Urology and the staff to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that my insurance company mail payment directly to North Texas Urology (or to the party who accepts assignment).

I hereby authorize North Texas Urology as my representative if my insurance is an ERISA plan.

I certify that the information I have given on my insurance coverage is correct and accurate.

Date:_____ Signature:_____
(Patient or Guardian)

I hereby permit North Texas Urology to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, Managed care organizations, IPA's, Medicare and/or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

I understand that I have the right to review the Notice of Privacy Practices of North Texas Urology. I have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. This request can be denied if required for treatment, payment collection or health care operations.

I permit a copy of this authorization to be used in place of the original.

Date:_____ Signature:_____
(Patient or Guardian)

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Patient History Form

This is a confidential record and will be kept in your doctors office. Information contained here will not be released to anyone without your authorization.

Name: _____ _____ _____ Today's Date: _____
Last First M.I.

Age: _____ Date of Birth: ____/_____/_____ Occupation: _____ Referring Doctor: _____
M D Y

CHIEF COMPLAINT : What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

HISTORY OF PRESENT ILLNESS:

When did you first notice the problem?

_____

_____

Is the problem constant or intermittent?

_____

_____

Does anything help or make the problem worse?

_____

_____

On a scale of 1 to 10, how severe is the problem?

1 2 3 4 5 6 7 8 9 10 (circle one)

Does anything else occur at the same time?

_____

_____

Where is the location of the problem?

_____

_____

MEDICAL HISTORY:

Please list your current medical illnesses:

_____

_____

_____

_____

_____

Please list your current medications and dosages:

_____

_____

_____

_____

_____

Please list all surgeries you have had:

_____

_____

_____

Please list all medical illnesses that run in your family:

_____

_____

_____

Please list any **medication allergies** you have:

_____

_____

Do you smoke?_____ If yes, how much _____

Are you a previous smoker? ____ When did you quit? ____

Do you drink alcohol? ____ If yes, how much? _____

How much caffeine do you take daily? _____

Please list the number of pregnancies and deliveries:

_____

Review of Systems **Patient Name:** _____

Do you now or have you ever had any problems related to the following systems?

Circle **Y**es or **N**o.

Constitutional Symptoms					
Fever	Y	N	Headache	Y	N
Chills	Y	N			
Eyes					
Blurred vision	Y	N	Double vision	Y	N
Pain	Y	N			
Ear/Nose/Throat/Mouth					
Ear infection	Y	N	Sinus problems	Y	N
Sore throat	Y	N			
Respiratory					
Wheezing	Y	N	Shortness of breath	Y	N
Frequent cough	Y	N			
Gastrointestinal					
Abdominal pain	Y	N	Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N			
Genitourinary					
Urine retention	Y	N	Urinary frequency	Y	N
Painful urination	Y	N			
Musculoskeletal					
Joint pain	Y	N	Back pain	Y	N
Neck pain	Y	N			
Skin					
Skin rash	Y	N	Boils	Y	N
Persistent itching	Y	N			
Nerological					
Tremors	Y	N	Numbness/Tingling	Y	N
Dizzy spells	Y	N			
Cardiovascular					
Chest pains	Y	N	Varicose veins	Y	N
High blood pressure	Y	N			

Physician Signature _____