AMARILLO UROLOGY ASSOCIATES

PATIENT HISTORY FORM

Name: _____ SSN _____
(Last) (First) (MI)

DOB: _____ Age:_____ Male____ Female____ Marital Status _____

Address:_____
(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address: _____

Preferred Method of Contact: Home ____ Cell ____ Work____ Email____ Text ____

Ethnicity: _____ Preferred Language: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referring Doctor: _____ Primary Care Doctor: _____

Doctor you are here to see today: _____

CHIEF COMPLAINT: (Main reason for today's visit) _____

Location of problem: Abdomen____ Kidney____ Pelvis____ Back____ Genitalia____ Other_____

How long does the problem last? 15 minutes___ 30 minutes___ 1 hour___ Other_____

Description of problem: Dull____ Sharp____ dull then sharp____ sharp then gone____

When did problem begin:_____ Anything else occurring at same time:_____

Does anything help or make problem worse: _____

Date_____

PAST MEDICAL HISTORY

SURGICAL PROCEDURES: List all past surgical procedures and the year they were performed

_____

_____

MEDICAL ILLNESSES: Circle any of the following you are currently being treated for:

Asthma Cancer Diabetes Emphysema Heart Disease High Blood Pressure Seizures Stroke

Other:

_____

_____

DRUG ALLERGIES: List all medications you are allergic to and the type of reaction:

_____

_____

CURRENT MEDICATIONS: List all of your current medications. Include dose and directions:

_____

_____

_____

_____

_____

_____

Preferred Pharmacy: _____

Preferred Lab: We perform prostate screening labs and low testosterone labs in-house. All other labs will be sent to **LabCorp, BSA, or NWTH**. If you or your insurance prefers a different outside lab please notify the clinical staff assisting you and a written order form will be given to you to take to the lab of your choice.

FAMILY HISTORY:

Father: Age living_____ Age deceased_____ Medical Illnesses: _____

Mother: Age living____ Age deceased____ Medical Illnesses:_____

Brothers: How many_____ Ages living_____ Ages deceased_____

Medical Illnesses_____

_____

Sisters: How many_____ Ages living _____ Ages deceased_____

Medical Illnesses_____

_____

PREVENTATIVE CARE

Do you currently use tobacco products: Yes____ No____ If yes, what type of tobacco:

Cigarettes____ Cigars____ chewing tobacco / snuff_____ Other_____

If no, did you ever: Yes____ NO____ When did you stop: _____

Do you drink alcohol: Yes____ No____ What type and how much:_____

Have you had a flu shot: Yes___ No___ When:_____ Pneumonia shot: Yes___ No___ When_____

Patients age 50 and older: Have you had a colonoscopy? Yes____ No____ When:_____

Patients age 65 and older: Do you have an Advanced Care Plan (Living Will): Yes____ No)____

Do you have a history of High Blood Pressure: Yes___ No___ Medication: _____

Do you have Diabetes: Yes____ No____ Medication:_____

REVIEW OF SYSTEMS

Do you now have or have you had any problems related to the following areas:
Please explain any YES answers in the space provided

Constitutional:
- Fever Y N
- Chills Y N
- Headache Y N
- Other:_____

Eyes:
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other_____

Immunologic (Allergy):
- Hay Fever Y N
- Drug Allergies Y N
- Other_____

Neurologic:
- Tremors Y N
- Dizziness Y N
- Numbness Y N
- Tingling Y N
- Other_____

Endocrine:
- Excessive Thirst Y N
- Too hot/Too cold Y N
- Tired/Sluggish Y N
- Other_____

Gastrointestinal:
- Abdominal Pain Y N
- Nausea/Vomiting Y N
- Indigestion/Heartburn Y N
- Other_____

Cardiovascular:
- Chest Pain Y N
- Varicose Veins Y N
- High Blood Pressure Y N
- Other_____

Integumentary (Skin):
- Skin Rash Y N
- Boils Y N
- Persistent Itch Y N
- Other_____

Musculoskeletal:
- Joint Pain Y N
- Neck Pain Y N
- Back Pain Y N
- Other_____

Ears/Nose/Throat/Mouth
- Ear Infection Y N
- Sore Throat Y N
- Other_____

Genitourinary:
- Urinary Retention Y N
- Urinary Frequency Y N
- Painful Urination Y N
- Blood in Urine Y N
- Other_____

Respiratory:
- Wheezing Y N
- Frequent cough Y N
- Shortness of Breath Y N
- Other_____

Hematologic/Lymphatic:
- Swollen Glands Y N
- Blood Clotting Y N
- Other_____

Psychologic:
- Satisfied with Life Y N
- Severely Depressed Y N
- Considered Suicide Y N
- Other_____

Patient Consent

- I consent to treatment necessary for the care of named patient.
- I acknowledge full financial responsibility for services rendered by Amarillo Urology Associates, L.L.P.
- I understand that payment of charges is due at the time of service unless other arrangements have been made prior to treatment.
- I authorize release of information to my insurance company in order to process claims and authorize payment to be made to Amarillo Urology Associates, L.L.P.
- I authorize release of my medical information to any other facility that I am referred to by this office.
- I authorize the use of my photo as part of my permanent medical record.
- I understand there may be times I am asked to see a mid-level practitioner at Amarillo Urology Associates. I consent to the services of a Physician Assistant/ Nurse Practitioner for my healthcare needs.

I have read and understand the Patient Consent and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

Signature of Patient or Responsible Party for Minor Date

_____

Printed Name of Patient

Notice of Privacy Practice

I have been informed that Amarillo Urology Associates, L.L.P. has a Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that upon request, I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative
(Printed Name)

Personal Representative relationship to Patient
(Printed Name)

I authorize that my medical information can be released as follows:

Information to be released to:

Name / Relationship to Patient
(Printed Name)

Signature of Patient

Date

Information to be released to:

Name / Relationship to Patient
(Printed Name)

Signature of Patient

Date

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, Discover and American Express.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided. Any balance due is your responsibility and is due upon receipt of a statement from our office.

No Insurance – Self Pay Discount

- A patient with no insurance will be required to make a deposit of $300 prior to seeing a doctor and will be billed the remaining amount due or receive a refund check if the $300 represents an overpayment.
- A patient who has no insurance will automatically receive a 25% discount off of billed charges. The 25% uninsured discount is not contingent upon payment time frame.

Lab Work

- For all Lab Work performed at Amarillo Urology Associates, L.L.P., it is the patient's responsibility to notify Amarillo Urology Associates, L.L.P. where your health plan dictates your work be sent

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Signature of Patient or Responsible Party of Minor _____ Date _____