UNIVERSITY UROLOGISTS

a division of UGF

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PATIENT NAME: _____ **DATE:** ____ / ____ / _____ **MED REC #:** _____

DATE OF BIRTH: ____ / ____ / _____ **AGE:** _____ **HEIGHT:** ____ **FT** ____ **IN** **WEIGHT:** _____ **LBS**

STREET ADDRESS & APT. # ☐ PERMANENT ☐ TEMPORARY	CITY AND STATE	ZIP CODE	SOCIAL SECURITY #

PATIENT'S EMPLOYER	OCCUPATION (CURRENT/FORMER)	HOW LONG EMPLOYED?	HOME PHONE NO.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	CELL PHONE NO.

SPOUSE'S / PARTNER'S NAME	NUMBER OF CHILDREN AND AGES	MARITAL STATUS					BUSINESS PHONE NO.
		S	M	DP	W	D	

PATIENT'S EMAIL	WHO CAN WE CALL IN AN EMERGENCY OTHER THAN YOUR HOME PHONE:

NORTHERN ADDRESS:

Street: _____ City: _____ St.: _____ Zip: _____

Name of Referring Physician: _____ Referring Physician's Phone #: _____

Referring Physician's Address: _____

Primary Care Physician (if Different) _____ Phone #: _____

Reason for your visit today: _____ Sex: ❒ Female ❒ Male

Pharmacy Name: _____ **Address:** _____ **City:** _____ **Zip:** _____

Pharmacy Phone #: _____ **Pharmacy Fax #:** _____

GOVERNMENT MANDATED QUESTIONS:

RACE ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander ☐ Other _____ ☐ Declined

PRIMARY LANGUAGE ☐ English ☐ Spanish ☐ Other _____ ☐ Declined

ETHNICITY (CHECK APPROPRIATE)

☐ NO, Not Hispanic, Latino, or Spanish Origin ☐ YES, Mexican, Mexican-American or Chicano Origin

☐ YES, Puerto Rican Origin ☐ YES, Cuban Origin ☐ YES, another Hispanic, Latino or Spanish Origin ☐ Declined

Drug Allergies:

Other Allergies: Latex ☐ Yes ☐ No _____

CURRENT MEDICATIONS: Please list any prescription medications, over-the-counter medications and vitamin supplements you take routinely: _____

Name of Drug or Supplement:	Strength (mg):	How often (# of times per day)
❒ See attached list		

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MEDICAL HISTORY: Please check any of the following conditions which **YOU** have had or presently have:

❒ Anemia	❒ Atrial Fibrillation	❒ Hepatitis C	❒ Neurologic disease	❒ Rheumatoid arthritis
❒ Chest Pain	❒ COPD	❒ Hyperlipidemia / Choles.	❒ Osteoarthritis	❒ Seizure disorder
❒ Arthritis	❒ Coronary Artery Disease	❒ High Blood Pressure	❒ Osteoporosis	❒ Sickle Cell disease
❒ Asthma	❒ Depression	❒ Inflammatory bowel	❒ Parkinson's Disease	❒ Thyroid disease
❒ BPH	❒ Diabetes	❒ Liver disease	❒ Peptic Ulcer disease /	❒ Kidney stones
❒ Cancer_____	❒ Diverticular disease	❒ Lupus	Reflux	❒ Valvular heart disease
❒ CVA (Stroke) TIA	❒ GERD	❒ Migraine headaches	❒ Peripheral vascular disease	
❒ Chronic UTIs	❒ Gout	❒ Heart Attack	❒ Renal/Kidney disease	
❒ Congestive Heart Failure	❒ Other: _____	_____	_____	

SURGICAL HISTORY: Please check any of the following procedures you have had performed and the date of the procedure

	Yr.		Yr.		Yr.	**Females Only**		**Males Only**	
❒ Appendectomy		❒ Cystoscopy		❒ Kidney removed			Yr.		Yr.
❒ Back Surgery		❒ ESWL		❒ Pacemaker		❒ Bladder suspension		❒ Orchiectomy	
❒ CABG / Heart		❒ Gastric bypass		❒ Perc stone removal		❒ Breast biopsy		❒ Penile Prosthesis	
❒ Gall Bladder		❒ Hernia repair		❒ Kidney stone removal		❒ C-Section		❒ Prostate Biopsy	
❒ Colon surgery		❒ Hip replacement		❒ Ureteral Stents		❒ Abd Hyst		❒ Prostatectomy	
❒ Coronary stent		❒ Knee replacement		**Other:**		❒ Mastectomy		❒ TURP	
❒ Cataracts		❒ Tonsils		❒ Laser Stone Extraction		❒ Vaginal Sling		❒ Vasectomy	
				❒		❒ TAH / BSO		❒ Prostate Radiation	
				❒		❒ Tubal ligation		❒ Prostate CA Surgery	
						❒ Vaginal Hyst		❒ Prostate Non CA Surgery	
						❒ Vaginal Delivery			
						#			

TOBACCO:

Uses tobacco? ❒ Yes ❒ No ❒ Former Tobacco type: _____ Packs per day:_____ Number of years: _____

CAFFEINE: ❒ Yes ❒ No

Type: _____

Amount daily:_____

ALCOHOL: ❒ Yes ❒ No

❒ Recovering

Urologic History:

Yes	No	
☐	☐	Urinary tract infections? _____
☐	☐	Kidney or bladder stones? _____
☐	☐	Blood in the urine? _____
☐	☐	Incontinence (loss of urine) or bedwetting? _____
☐	☐	X-rays of the kidneys? _____
☐	☐	Previous urologic tests or procedures? _____
		Other _____

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring health care provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims assignment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductibles, co-insurances and co-pays. I understand that I am financially responsible for any charges not covered by my insurance and if I fail to give updated current information and the claim is denied, I will be responsible for the entire balance.

In the event your check is returned for any reason, your account will be charged $35. If we determine your account should be placed with an outside collection agent or an attorney, you will be assessed an additional 30% of the balance due.

Signed: _____ Date: _____