UROLOGY ASSOCIATES

Case No. _____

Date _____

Patient: _____ Male: ____ Female: ____
First Middle Last

Address: _____
Street Address City State Zip Code

Home Phone #: (____) _____ Work Phone #: (____) _____

Cell Phone #: (____) _____ Social Security Number ___ - __ - ____

Age: _____ Date of Birth: _____
(MM/DD/YYYY)

Employer: _____ Position: _____

Address: _____ Phone #: _____

Spouse's Name: _____ Social Security #: ___ - __ - _____

Employer: _____ Phone #: _____

Responsible Party: _____

Address (If Different): _____
Street Address City State Zip Code

Phone #: _____ Work #: _____

Nearest Friend of Relative: _____ Relationship: _____

Address: _____ Phone #: _____

Referred By Dr.: _____

INSURANCE INFORMATION

Insurance Co. #1: _____ Policy #: _____

Holder's Name: _____ DOB: _____

Insurance Co. #2: _____ Policy #: _____

Holder's Name: _____ DOB: _____

In order to minimize fees and billing expenses, it is agreed that the patient will pay for each office visit as it occurs; that the patient authorizes The Urology Clinic to release information, in connection with any treatment, to the insurance carrier; that if charges are not paid at time of service, financial arrangements will be made with the business offices; that if payment obligations are not met within 90 days and the account becomes past due, a charge of 1.5% interest per month will be added to the balance; and that if the account is referred to an attorney or credit bureau, the patient will pay all cost of collection, including fees, court costs and other expenses.

SIGNATURE: _____
Patient or responsible party

PATIENT QUESTIONNAIRE

DATE:	
NAME:	AGE:
OCCUPATION/EMPLOYER:	
REASON FOR VISIT:	

PAST SURGICAL HISTORY

(If you have had any surgeries – state the year and type of operation.)

YEAR	SURGERY

DRUG ALLERGIES

DRUG	REACTION

PAST MEDICAL HISTORY & FAMILY HISTORY

Please check if you (self) or any blood relative had any of the following conditions.

	SELF	RELATION		SELF	RELATION
1) Recent Weight Loss			17) Kidney / Bladder Prob.		
2) Migraine Headaches			18) Neurological		
3) Epilepsy / Convulsions			19) Arthritis		
4) Eye Disease (other than glasses)			20) Osteoporosis		
5) Hearing Disorder			21) Cancer – *Type:*		
6) Recurrent – Nose Bleeds					
Sinus / Throat Infect(s)			22) Bleeding Disorder		
7) Angina – Chest Pain			23) Blood Transfusion(s)		
8) Heart Attack			24) Anemia		
9) High Blood Pressure			25) Diabetes		
10) Stroke			26) Thyroid		
11) High Cholesterol			27) Alcohol or Drug Abuse		
12) Heart Valve Disorder			28) Mental Illness		
13) Lung Disease			29) Depression		
14) Stomach Ulcer			30) Psoriasis / Eczema		
15) Bowel Problems			32) Accident Major		
16) Liver Disease / Hepatitis					

LIST ALL MEDICATIONS YOU TAKE

MEDICATION	DOSE	TIMES/DAY

Do you currently or have you ever smoked?

Yes or No (circle one)

If yes, how many packs per day?

_____

How many years have/did you smoke?

_____

If you no longer smoke, what year did you quit?

_____

Do you drink alcohol?

Yes or No (circle one)

If yes, how many drinks?

_____ per day / month (circle one)