URLOGY ASSOCIATES

Case No. ______________________________

Date ________________________________

Patient: ____ Male: ____ Female: ____

First Middle Last

Address: ____

Street Address City State Zip Code

Home Phone #: (____) _____________ Social Security Number ___ - __ - ____

Age: _______ Date of Birth: ____________
(MM/DD/YYYY)

Father's Name: ______________________ Social Security #: ___ - __ - _____

Address: ___________________________ Phone #: __________________________

Employer: ___________________________ Position & Phone #: _______________

Mother's Name: ______________________ Social Security #: ___ - __ - _____

Address: ___________________________ Phone #: __________________________

Employer: ___________________________ Position & Phone #: _______________

Responsible Party: ____

Address (If Different): ____

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)