Patient Information Sheet

Patient Name:	**Acct #:**	Date of Birth:	
Marital Status:	Sex:	Age:	
Address:	City:	St:	Zip:
Soc. Sec.#:	**Home Ph.:**	**Cell:**	**Work:**
	Please circle the Phone number you would prefer to be contacted at		
Email Address:	Primary Language:		

RACE: ***(If Blank - Please Check appropriate box)***

☐ AMERICAN INDIAN / ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN
☐ OTHER PACIFIC ISLANDER ☐ WHITE ☐ MORE THAN ONE RACE ☐ REFUSED TO REPORT

ETHNICITY: ***(If Blank - Please Check appropriate box)***

☐ HISPANIC / LATIN AMERICAN ☐ NON-HISPANIC / LATIN AMERICAN ☐ REFUSED TO REPORT

Responsible Party:	Sex:	Date of Birth:	
Address:	City:	St:	Zip:
Soc. Sec.#:	Home Ph.:	Cell:	Work:
	Please circle the Phone number you would prefer to be contacted at		
Emergency Contact Name:		Date of Birth:	
Home Ph.:	Cell Ph.:	Relationship:	
Primary Care Physician:	**Referring Provider:**		

HEATLH INSURANCE INFORMATION	
PRIMARY INSURANCE	SECONDARY INSURANCE
Carrier Name:	Carrier Name:
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:
Policy ID:	Policy ID:
Group #:	Group #:
Specialist Co-Pay:	Specialist Co-Pay:

I hereby assign any/all medical and/or surgical benefits to which I am entitled through Medicare, Medicaid, Workers Compensation, or any other governmental or private insurance or health plans to Urologic Surgeons. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

I understand that I am responsible for all charges, whether or not I have Insurance. In the event that I have insurance, I understand that I am responsible for any In-network or Out-of-network benefit determination, including but not limited to Deductibles, Co-Pays and Co-insurances.

I consent to the use or disclosure of my protected health information **by Urologic Surgeons** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations **of Urologic Surgeons**. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidence of my signature on this document.

______________________________ ______________________________

Signature of Patient or Responsible Party **Date**

UROLOGIC SURGEONS

CHRISTOPHER M. CASSISI, M.D.
DARYLL BULLEN, M.D.
SEAN P. MCLAUGHLIN, M.D.

6420 N.W. 9th Boulevard, Suite 2
Gainesville, Florida 32605
(352) 331-2332
FAX (352) 331-6515

CONSENT FORM

Urologic Surgeons is hereby authorized to release any Personal Health Information necessary to carry out treatment including referrals to other physicians and/or payment for medical claims to insurance companies on my behalf.

This consent is also valid for the request of medical reports, diagnoses/prognoses, medical history, results of tests and bills whether payable by myself or by other parties such as health insurance that may be necessary for processing health claims.

Urologic Surgeons will not release any information concerning the patient to any legal entity without express written consent from the patient.

This consent form is not restricted to time or subject matter.

I understand that I may revoke this consent at any time by notifying Urologic Surgeons in writing.

Please list any relatives or persons that you authorize access to your health information:

Name	**Relationship**
______________________	______________________
______________________	______________________

Patient's Name______________________ **SS#** ______________________

Patient's Signature ______________________ **Date**______________________

Witness Signature______________________

over→

PATIENT COMMUNICATION FORM

PLEASE PRINT CLEARLY.

PATIENT NAME: ______________________________ DATE OF BIRTH: ______________________

ADDRESS: ____

____

We believe that good communication is key to a strong patient-physician relationship. There are times when we need to notify you of test results or appointment changes. Please list the telephone number you would like us to call.

Please list below and indicate whether ok to leave a voice mail message.

☐ Home ________________________ Message OK? ☐ Yes ☐ No

☐ Office ________________________ Message OK? ☐ Yes ☐ No

☐ Cell ________________________ Message OK? ☐ Yes ☐ No

☐ Fax ________________________ Message OK? ☐ Yes ☐ No

I give permission for the following family members, significant others, etc. to receive information about my test results, referrals, medical condition, etc.

____

____

____

I understand that on occasion, due to technical problems with mailing, faxing, etc. my provider may not have received my test results as expected. If I have not been notified of my results within one month of the test, it is my responsibility to telephone the office for follow up. It is also my responsibility to notify my physician if I have not been contacted regarding planned referrals to other physicians. I understand that I am responsible to notify this office of any change in the above information.

____ ______________________

Signature Date

PATIENT HISTORY FORM

LAST NAME: ________________ FIRST NAME: ______________ MI: _____ HEIGHT: _________

SOCIAL SECURITY #: ____________________ DOB: ___________ AGE: ____ WEIGHT: _________

RACE: ______________ ETHNICITY: ______________ PREFERRED LANGUAGE: ______________

WHAT IS THE REASON FOR YOUR VISIT TODAY? ______________________________________

____

____

SURGICAL HISTORY	MEDICAL HISTORY
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

FAMILY HISTORY

Father: ALIVE DECEASED

Age: ________ Cause: ____________________

Mother: ALIVE DECEASED

Age: ________ Cause: ____________________

SOCIAL HISTORY

Do you smoke?	YES	NO	Do you drink caffeinated beverages? If yes, how many?	YES	NO
Have you ever smoked?	YES	NO	Do you drink alcohol?	YES	NO
Do you use smokeless tobacco?	YES	NO	Have you ever drank alcohol?	YES	NO
Do you use recreational drugs?	YES	NO	Have you had a blood transfusion?	YES	NO

Do you have any allergies to medications? YES NO
If yes, please list any allergies and reactions below:

____

____

Are you taking any medications? YES NO If yes, please list all medications below.

____

____

____

____

REVIEW OF SYMPTOMS

PLEASE CIRCLE ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

FEVER	CHILLS	WEIGHT LOSS
BLURRY VISION	DOUBLE VISION	CATARACTS
HEARING LOSS	NASAL STUFFINESS	SORE THROAT
CHEST PAINS	SWOLLEN ANKLES	IRREGULAR HEARTBEAT
SHORTNESS OF BREATH	WHEEZING	CHRONIC COUGH
ABDOMINAL PAIN	NAUSEA/VOMITING	CHANGE IN BOWELS
INCONTINENCE	PAINFUL URINATION	BLOOD IN URINE
CHRONIC BACK PAIN	CHRONIC NECK PAIN	SORE MUSCLES
RASH	PERSISTENT ITCHING	SKIN CANCER HISTORY
NUMBNESS	TINGLING	DIZZINESS
SWOLLEN GLANDS	ABNORMAL BLEEDING	TRANSFUSION HISTORY
	NONE OF THE ABOVE	

OTHER: ____

____