PATIENT INFORMATION UPDATE

NAME: _____ DOB: _____ TODAY'S DATE: _____

HEIGHT: _____ WEIGHT: _____

LIST ANY PRESCRIPTION AND OVER THE COUNTER MEDICATIONS BELOW:

_____

_____

_____

_____

_____

_____

_____

LIST ANY DRUG ALLERGIES AND REACTIONS BELOW:

_____

_____

HAVE YOU BEEN HOSPITALIZED OR DIAGNOSED WITH ANYTHING SINCE YOUR LAST VISIT?

YES? NO?

IF YES, PLEASE EXPLAIN: _____

_____

_____

PRIMARY CARE DOCTOR: _____

PRIMARY PHARMACY: _____

SECONDARY PHARMACY (if applicable): _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

_____

_____

_____

_____

IF YOU HAVE HAD ANY RECENT LABS DONE, PLEASE GIVE A COPY AT CHECK-IN

PLEASE ENSURE ALL INFORMATION IS CORRECT FOR YOUR MEDICAL RECORDS

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: _____

_____

UROLOGIC SURGEONS

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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