BRAZOSPORT UROLOGY

TODAY'S DATE_____/_____/_____

LAST NAME_____ FIRST NAME _____MI _____

ADDRESS_____CITY_____STATE_____ ZIP CODE_____

SEX (*CIRCLE ONE*) Male — Female SSN_____-_____-_____ DATE OF BIRTH_____/_____/_____

HOME PHONE (_____) _____-_____CELL (_____) _____-_____WORK (_____) _____-_____

MARITAL STATUS (*CIRCLE ONE*) Single / Married / Divorced / Separated / Widowed / Partner

PRIMARY CARE AND/OR REFERRING PHYSICIAN_____

EMERGENCY CONTACT_____RELATIONSHIP_____PHONE_____

EMPLOYER OF PATIENT OR GUARANTOR_____

INFORMATION RELEASE: [Health information collected here about me may be disclosed to the following persons.]

NAME_____RELATION_____

NAME_____RELATION_____

IF THE PATIENT IS UNDER THE AGE OF 18:

RESPONSIBLE PARTY_____RELATIONSHIP_____PHONE_____

PLEASE TELL US HOW YOU HEARD ABOUT US: _____

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to the above named doctor/group for any services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services. I hereby assign benefits to the doctor or group indicated on this claim. I understand that I am responsible for the co-pay at time of visit. Having insurance is not a substitute for payment. I further understand that if my benefits are not verifiable, I might be responsible for charges in full with a possible reimbursement after verification is obtained. A copy of this signature is as valid as the original. I also acknowledge I am responsible for any fraudulent information I provide to this office or in accordance with my benefits.

By signing this I also acknowledge that I have read and understand Brazosport Urology's Notice of Privacy Practices. A copy is located in the lobby and given to a patient upon request. I authorize the person(s) listed above to receive all health information about appointments, treatments and/or other information pertinent to my health care provided by Brazosport Urology.

We emphasize that as a medical care provider, our relationship is with you and not your insurance company. We cannot be responsible for any loss of benefits. If you have any questions concerning the above information, please do not hesitate to ask us. We are here to help you.

If you would like your labs processed somewhere specific, you need to specify this in writing. We will provide a form upon request and will do our best to make sure this happens.

If you do not show up for your appointment without 24-hour advance notice cancelling, you will be charged up to $250. This is done in order to preserve the schedule. Thank you.

Signature of Patient or Guarantor_____ Date_____

Health History

Allergies (drug, food, contrast and reactions) _____

Past Medical History : _____

_____

_____

Past SurgicalHistory: _____

_____

Other Hospitalizations: _____

_____

Please list any pharmaceutical and/or natural medications (including vitamins) that your are taking or have taken in the last year

Medications	Dosage	*Reason for taking*

Do you take any of the following over-the-counter medications? Please check or circle any that apply:

____Aspirin ___Ibuprofen / Acetaminophen ____Antihistamine ____ Sleeping pills

____Laxatives ____ Head /Cold Remedies ____Antacid _____Medicine to stay awake

Do you drink caffeine if so please circle one (tea, soda, coffee)? If so how much?_____

Family History-(cancers or early deaths)_____

Do you smoke or did you ever?_____ How much?_____ When did you quit?_____

Do you drink alcohol?_____ How much?_____ Any illicit drugs?_____

Review of Systems

Circle all following below areas in which you have had problems (not previously mentioned above):

Heart Lung Muscles/Bones Endocrine (thyroid, diabetes, etc) Stroke

Skin Emotional Gastrointestinal Kidney Constipation Recent Weight Loss

Explain any above_____

For men only

Have you ever had an abnormal prostate exam?_____ If yes, did you have a prostate biopsy? _____

If so, when and where?_____

For women only

Last menses or Menopause_____
Number of pregnancies_____Number of Vaginal deliveries_____ Number of caesarian sections_____

Have you seen a Urologist before?_____ If so when?_____For what reason?_____

_____

What is your most important reason for making this appointment?_____

_____

List any other Urological concerns you may have_____

_____

FOR DOCTOR USE ONLY:

_____ FREQUENCY
_____ NOCTURIA
_____HESITANCY
_____STREAM
_____PVD
_____STRAIN

_____DYSURIA
_____URGENCY
_____LEAKAGE
_____SUI
_____UI
_____SOAKED/DAMP
_____PAD / LINER

_____STONES
_____UTI'S
_____DISCHARGE
_____HEMATURIA/GROSS_____