UNITY Urology

Female Intake Form

| MRN: | Patient Name: | | Date of Birth: |
|---|---|---|---|
| Address: | City: | State: | Zip: |
| Home Phone: | Cell Phone: | | Sex: |

***PATIENT INFORMATION***

Social Security #: _____-_____-_____ Date of Birth : _____/_____/_____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Sex: ☐ Male ☐ Female Email: _____

Employer: _____ Full Time Part Time Student

PCP: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

***IF PATIENTS INSURANCE IS NOT THROUGH EMPLOYER OR PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION.***

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Sex: ☐ Male ☐ Female Date of Birth : _____/_____/_____ Social Security #: _____-_____-_____

Responsible Party Employer: _____

Relationship to Patient: _____

***MEANINGFUL USE DATA***

**Race**: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

**Ethnicity**: ☐ Hispanic ☐ Non-Hispanic **Preferred Language**: ☐English ☐ Spanish ☐ Other: _____

***IN CASE OF EMERGENCY***

Relative/Friend: _____ Relationship: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Unity Urology or my insurance company to release any information required to process my claims.

**PATIENT SIGNATURE:** _____ **DATE:** _____

| MRN: | Patient Name: | | Date of Birth: |
|---|---|---|---|
| Address: | City: | State: «Pstate» | Zip: |
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**UNITY UROLOGY**

**PF-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Erica Carter, Office Manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

**By my signature below, I acknowledge receipt of the Notice of Privacy Practices.**

_____

**PRINT PATIENT'S NAME**

_____ _____

Patient or Legally authorized individual signature Date / Time

_____ _____

Printed Name if signed on behalf of the patient Relationship to Patient

**(Notation, if any, by staff)**

**AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:**

_____ _____

**Print Name of person/organization** **Relationship to Patient**

_____ _____

**Print name of person/organization** **Relationship to Patient**

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**Financial Agreement**

Patient SSN: «PSSN»

For services rendered to the patient named below, I, the undersigned, agree to pay all professional and/or outpatient charges not covered by insurance. This includes any co-payments, co-insurance and deductibles that may be owed. **I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.**

Patient and /or Guardian Signature _____ Date _____

**Authorization to Release Medical Information and payment of Insurance Benefits**

I hereby authorize Unity Urology or my attending physician to release or disclose to insurance companies and/or outpatient benefits programs information from my medical record pertaining to my treatment as needed to process insurance claims. Furthermore, I hereby assign payment directly to Unity Urology benefits wherein specified and otherwise payable to me but not to exceed Unity Urology regular charges for medical treatment. I understand that I am financially responsible for charges not covered by this authorization.

Patient and /or Guardian Signature _____ Date _____

**Statement to Permit Payment of Medicare Benefits to Physician (Medicare Patients Only)**

I certify that the information given by me in applying for payments under the Title XVII of the Social Security Administration or it intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payment for physician services to the physician or organization furnishing the services, and authorize such physician or organization to submit claims to Medicare for payment.

Patient and /or Guardian Signature _____ Date _____

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Female Intake Form

MRN:_____ Patient Name:_____ **Date:** _____

**Medical Doctor/PCP:** _____

**Why are you seeing the physician today:** _____

**When did your problem start:** _____

**Pharmacy (Name & Location):** _____

**Hospital Preference:** ☐ Laughlin ☐ Takoma

**My Main Problems are:**

Blood in urine Bladder Cancer Bladder Infection Bladder Pain Dropped Bladder
Kidney Stones Interstitial Cystitis Leak Urine Overactive Bladder
Other _____

**Allergies** None Latex X-Ray Dye Betadine Other:
_____

**Medications** – See Medication Form

**Surgical History** ***(please circle all that apply)***

Appendectomy ☐ Bladder Tack ☐ C – Section # _____ ☐ Cystoscopy ☐ Gallbladder
Heart Bypass ☐ Hysterectomy ☐ Kidney Stone Surgery ☐ Sling (TVT) Hernia
Vaginal Deliveries # ____ Other _____ ☐

**Medical History** ***(please circle all that apply)***

Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur Hepatitis
Hypertension ☐ Last Period: _____ ☐ Menopause ☐ Parkinson's Strokes
Pregnant (Now) ☐ ☐ HIV ☐ Cancer: _____
Other _____ ☐

**Family History** ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease

**Social History**

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Number of Children: _____
Have you ever received Blood? ☐ No ☐ Yes
Smoke: No ☐ Yes
Alcohol Use: ☐ None ☐ Social ☐ Light ☐ Moderate ☐ Excessive
*If Yes, how many packs per day:* _____
Daily Caffeine Drinks: 0 1 2 3 4 5 ____

**My Symptoms are: (please circle all that apply)**

| | | | | |
|---|---|---|---|---|
| **Con:** | Chills | Fever | Weight Loss | |
| **Eye:** | Blurry Vision | Cataracts | Double Vision | |
| **ENT:** | Hearing Loss | Nasal Stuffiness | Seasonal Allergies | Sore Throat |
| **Car:** | Chest Pains | High Blood Pressure | Irregular Heartbeat | Swollen Ankles |
| **Resp:** | Chronic Cough | Shortness of Breath | Trouble Breathing | Wheezing |
| **Gas:** | Abdominal Pain | Change in Bowels | Constipation | Nausea/Vomiting |
| **Gent:** | Blood in Urine | Incontinence | Painful Urination | Urinary Frequency |
| | Urinary Urgency | Weak Stream | | |
| **Musc:** | Chronic Back Pain | Chronic Neck Pain | Sore Muscles | Weakness/Legs |
| **Skin:** | Persistent Itching | Rash | Skin Cancer History | |
| **Neur:** | Anxiety | Depression | Dizziness | Frequent Headache |
| | Numbness | Overly Stressed | Tingling | |
| **Lymp:** | Abnormal Bleeding | Swollen Glands | Transfusion History | |

**Urinary Symptom(s) are:** Urgency Leakage Straining Abdominal Pain Bladder Pain
Pain in Side R / L Not Emptying Bladder Urinating at Night #_____

Do you have a catheter in today? ☐ No ☐ Yes *If yes, who put it in?* _____

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**Prescription Medication**

| Medication | Dosage | Directions |
|---|---|---|
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**Over the Counter Medications** (Asprin, Vitamins, Diet Pills, etc. )

| Medication | Dosage | Directions |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |

**Current Allergies** (Medications, Food Procucts)

| Medication | Dosage | Directions |
|---|---|---|
| | | |
| | | |
| | | |