



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: _____

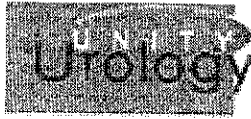
IN CASE OF EMERGENCY

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:** _____



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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



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

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

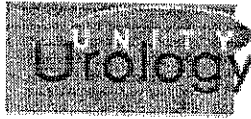
Date

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



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: (please circle all that apply)

Enlarged Prostate	Blood In Urine	Prostate Cancer	Bladder Infection	Kidney Stones
High PSA	Prostate Infection	Urinary Leakage	Bladder Cancer	
Erectile Dysfunction	Overactive Bladder	Lump in Testicle	Other: _____	

Allergies None Latex X-Ray Dye Betadine Other: _____

Medications:- Please see Medication Form

Surgical History (please circle all that apply)

Appendectomy	Cystoscopy	Gallbladder	Heart Bypass	Hernia
Prostate Biopsy	Prostate Surgery	Kidney Stone Surgery		
Other _____				No Changes

Medical History (please circle all that apply)

Diabetes	Emphysema	Heart Attack	Heart Murmur	Hepatitis	HIV
Hypertension	Strokes	Other: _____			
Cancer:	Prostate	Kidney	Testis	Bladder	No Changes

Family History Prostate Cancer Kidney Cancer Kidney Stones Heart Disease

Social History

Number of Children: _____ Martial Status: Single Married Divorced Widowed

Smoke: No Yes Have you ever received Blood? No Yes

If Yes, how many packs per day: _____ Alcohol Use: None Social Light Moderate Excessive

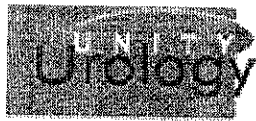
Daily Caffeine Drinks: 0 1 2 3 4 5 _____

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
Car: Chest Pains	High Blood Pressure	Sore Throat
Resp: Chronic Cough	Shortness of Breath	Swollen Ankles
Gas: Abdominal Pain	Change in Bowels	Trouble Breathing
Gent: Blood in Urine	Incontinence	Constipation
Urinary Urgency	Weak Stream	Painful Urination
Musc: Chronic Back Pain	Chronic Neck Pain	Nausea/Vomiting
Skin: Persistent Itching	Rash	Urinary Frequency
Neur: Anxiety	Depression	Sore Muscles
Numbness	Overly Stressed	Skin Cancer History
Lymp: Abnormal Bleeding	Swollen Glands	Dizziness
		Tingling
		Transfusion History
		Frequent Headache
		Weakness/Legs

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

Over the Counter Medications (Asprin, Vitamins, Diet Pills, etc.)

Medication	Dosage	Directions

Current Allergies (Medications, Food Products)

Medication	Dosage	Directions