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William Mauch, M.D.
Ryan Payne, M.D.
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SALINA UROLOGY ASSOCIATES

218 S Santa Fe Ave
Salina, KS 67401
(p) 785-827-9635
(f) 785-827-6697
www.salinaurology.com

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Social Security Number: _____

Primary Care Physician: _____ Referring Physician: _____

RESPONSIBLE PARTY:

Name: _____ Date of Birth: _____

Mailing Address: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Relationship to Patient: _____

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ Insured's Employer: _____

Insurance ID: _____ Insurance Group Number: _____

Insured's Name as it appears on the card: _____

Insured's Date of Birth: _____ Insured's Social Security Number: _____

Secondary Insurance Carrier: _____ Insured's Employer: _____

Insurance ID: _____ Insurance Group Number: _____

Insured's Name as it appears on the card: _____

Insured's Date of Birth: _____ Insured's Social Security Number: _____

Assignment of Benefits & Authorization to Release Medical Information

I request that payment of authorized benefits, Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to Salina Urology Associates, PA, for any services furnished to me by provider. I authorize any holder of medical information about me to release it to the Division of Family Services, Health Care Financing Administrator, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

I understand that I am responsible for payment of charges regardless of having insurance.

Patient Signature: _____ Date: _____

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Patient History Intake Form

Patient Name: _____ Date of Birth: _____ Today's Date: _____

State in your own words your reason for appointment:

_____

Preferred Pharmacy: _____ Address: _____

Do you have or have you ever had an infection that is resistant to antibiotics or required a health care provider to use isolation techniques?

(MRSA/ESBL) _____ YES _____ NO _____

Circle or list your medical conditions:

Asthma	Sleep Apnea	Cancer, type: _____	COPD/Emphysema
Parkinson's Disease	Diabetes	Seizures	Glaucoma
Heart Disease	Kidney Disease	Hepatitis/Liver Disease	High Blood Pressure
Multiple Sclerosis	HIV/AIDS	Stroke/TIA	Tuberculosis

Other: _____

Surgical History: List all surgeries you have had

_____

Social History:

Occupation: _____ Marital Status: Single Married Widowed Divorced

Of Children: _____ # of Daily Caffeine Drinks: _____

Tobacco Use: Yes, I currently smoke _____ packs/day for _____ years

No, I formerly smoked _____ packs/day for _____ years and quit _____

No, I have never smoked

Alcohol Use: Yes Not anymore (quit _____ years ago) Never

Have you ever had a blood transfusion: Yes No

Family History:

Has any blood relative had any of the following illnesses? Circle all that apply and list relationship

Bladder Cancer	Breast Cancer	Diabetes	Heart Attack
Kidney Cancer	Kidney Disease	Stroke	Prostate Caner
Urinary Stones			

Other: _____

Urological Symptoms: Circle all that apply

Burning with Urination	Pain with Urination	Frequency of Urination	Urgency of Urination
Leakage of Urine	Blood in Urine	Hesitancy / Straining with Urination	Kidney Stone
Difficulty Emptying Bladder	Decreased Urination Stream	Starting/Stopping of Urination Stream while voiding	Intimacy Issues

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Patient Medication Information

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Do you require antibiotics prior to procedures? YES NO

Have you ever had reactions/issues with anesthesia? YES NO

Are you allergic to IODINE or CONTRAST DYE? YES NO

Please list Allergies to Medication and Allergic Reaction:

_____
_____
_____
_____

Please list any other Allergies:

_____
_____
_____
_____

Medications:
Include all over the counter medications, vitamins, herbals and aspirin

Medication Name: Dose: How Often: Reason:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you take any Blood Thinners? YES NO

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RELEASE OF INFORMATION

PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE

Patient Name: _____ DOB: _____

I hereby allow Salina Urology Associates, PA to disclose the following Protected Health Information:

- □ Appointment times and dates
- □ Tests that have been received and Test results
- □ Diagnosis, Records, Examination Information
- □ ALL INFORMATION

To the following people because they are involved with my health care or payment:

- □ Spouse Name: _____
- □ Child Name: _____
- □ Parent/Guardian Name: _____
- □ Other Name: _____

In the following forms of communication:

- □ Home phone # _____
- □ Work phone # _____
- □ Cell phone # _____

If unable to reach me:

- □ You may leave a detailed message
- □ Please leave a message asking me to return your call

I authorize Salina Urology Associates, PA to provide any information, reports, or copies of records which may be requested by other doctors, hospitals, insurance companies, etc.

Patient Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

- I acknowledge that I have had an opportunity to review and/or received a copy of Salina Urology Associates, PA "Notice of Privacy Practices". *You may request a copy of our Notice of Privacy Practices.*
- I consent for Salina Urology Associates, PA to use and disclose my personal health information to carry out treatment, payment, and all related healthcare services.
- I understand Salina Urology Associates, PA may call or leave a message on an answering machine, voicemail, or in person in reference to any items that assist in meeting my healthcare needs, such as appointment reminders, insurance related information, laboratory results, clinical care information, etc. I also understand Salina Urology Associates, PA may mail correspondence to my home or other designated locations such as appointment reminders, billing statements, brochures, etc.
- I understand I may revoke my consent to the above items in writing, except to the extent that the practice has already made disclosure in reliance upon prior consent. I understand if I do not sign this consent, Salina Urology Associates, PA may decline to provide services to me.

Patient Signature: _____ Date: _____