GENERAL INFORMATION

PATIENT INFORMATION:

NAME:_______________________________________DATE OF BIRTH:__________________
first middle last

ADDRESS:____
street city state zip

PHONE:__________________________CELLULAR PHONE:____________________________
area code & number area code & number

PLACE OF EMPLOYMENT:____

EMPLOYERS ADDRESS:____
street city state

WORK PHONE:____

SOCIAL SECURITY NUMBER:____

FAMILY PHYSICAN:____

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SPOUSE OR RESPONSIBLE PERSON:

NAME:_____________________________________PHONE NUMBER:__________________
first middle last

ADDRESS:____
street city state zip

RELATIONSHIP TO PATIENT:_________________________SS#______________________

PLACE OF EMPLOYMENT:____

****

INSURANCE INFORMATION:

KIND OF INSURANCE:____

INSUREDS NAME AS IT APPEARS ON INS. CARD:_______________________________

INSUREDS DOB:__________________INSUREDS SS#:________________________________

POLICY NUMBER:_____________________________GROUP NUMBER:_________________

(HSA ACCOUNT: ☐ YES ☐ NO) DEDUCTIBLE:____________________________

SECONDARY INSURANCE:

KIND OF INSURANCE:____

INSUREDS NAME AS IT APPEARS ON INS. CARD:__________________________________

INSUREDS DOB:__________________INSUREDS SS#:________________________________

POLICY NUMBER:_____________________________GROUP NUMBER:_________________

SALINA UROLOGY ASSOCIATES, P.A.

Medical History

Please complete this form prior to your appointment as it helps us to get the most out of your visit. Thank you for helping us.

Name________________________________ Date of Birth_________________Today's date_________________

State in your own words your reason(s) for seeing the doctor.

____

____

______

Circle or list your medical problems:

Cancer	Heart Disease	High blood pressure	Stroke/TIA
COPD/emphysema	Asthma	Diabetes	Hepatitis/Liver disease
Kidney Disease	HIV	Epilepsy	Tuberculosis
Multiple Sclerosis	Parkinson's	Back or Neck injury	Glaucoma

Other:

______________________ ____________________ _____________________ _________________________

______________________ ____________________ _____________________ _________________________

Surgical history: List all surgeries you have had.

______________________________ _________________________________ ____________________________

______________________________ _________________________________ ____________________________

______________________________ _________________________________ ____________________________

Social history:

Occupation (previous, if retired)____

Have you worked around chemicals? YES NO

Marital Status: (Please Circle) Married Widowed Divorced Single Number of children: _________

Alcohol consumption:____

Tobacco Use: YES I currently smoke______packs/daily for_____years

NO I formerly smoked______packs/daily for_____years

NO I have never smoked.

Has any blood relative had any of the following illnesses: Circle all that apply.

Bladder Cancer	Prostate Cancer	Breast Cancer	Heart Attack	Stroke	Diabetes
Kidney Cancer	Urinary stones	Kidney disease	HIV	Thyroid disease	

Other:____

<u>Urological Problems</u> *(Circle all that apply)*

Burning/pain with urination	Blood in urine	Difficulty starting stream	Inability to hold urine
Frequent urination	Urination at night	Decreased urinary stream	Bedwetting
Sexually transmitted disease/s	Kidney stones	Bladder stones	Kidney infections
Bladder infections	Kidney cancer	Bladder cancer	Fistula (hole in bladder)
Interstitial cystitis	Prostate Cancer	Prostatitis	Cystocele (fallen bladder)
Kidney Xrays	Pelvic pain	Pelvic surgery	Intimacy problems

Please complete back side!

Do you now or have you ever had problems related to the following systems? Circle Yes or No.

Constitutional symptoms

Weight loss	Y	N
Fever	Y	N
Chills	Y	N
Headache	Y	N

Other______________________

Eyes

Blurred vision	Y	N
Double vision	Y	N
Eye pain	Y	N

Other______________________

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Concussion	Y	N

Other ______________________

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other______________________

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Indigestion/heartburn	Y	N
Blood/tarry stools	Y	N

Other ______________________

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other ______________________

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other ______________________

Ear/Nose/Throat

Ear infection	Y	N
Frequent sore throat	Y	N
Sinus problem	Y	N
Nose bleed/s	Y	N

Other ______________________

Respiratory

Wheezing	Y	N
Persistent cough	Y	N
Shortness of breath	Y	N

Other ______________________

Hematologic/Lymphatic

Anemia	Y	N
Swollen glands	Y	N
Clotting problem	Y	N
Blood transfusion	Y	N

Other ______________________

Cardiovascular

Chest pain	Y	N
Irregular pulse	Y	N
Palpitations	Y	N
High blood pressure	Y	N
Heart murmur	Y	N
Swollen ankles	Y	N
Pain in legs (walking)	Y	N

Other ____________________

Allergic/Immunologic

Hay Fever	Y	N
Food allergies	Y	N

Other ______________________

Name ________________________________ **Date**______________________

Date of Birth__________________________ **Updated** ___________________

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MEDICATION SHEET

Do you require antibiotics prior to procedures?	**Yes**	**No**
Have you ever had problems with anesthesia?	**Yes**	**No**
Are you allergic to IODINE or CONTRAST DYE?	**Yes**	**No**

Allergies:

____
____
____
____
____
____
____

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

Name	**Dose**	**How often**	**Reason**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:____________________________________Record Number:___________
Date of Birth:___________________Social Security Number:______________________
Address:_______________________City:____________State:_________Zip:_________

Name of Person Giving Authorization if other than patient:________________________
Address:_______________________City:____________State:_________Zip:_________
I am the_______Patient_______Guardian_________Conservator________Other Designee with Authority

Release to Third Party Payers: I herby authorize Salina Urology Associates, P.A. its physicians, agents and employees to release all of my medical records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of hospitalizations and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric conditions, and or sexually transmitted diseases, including AIDS information to any insurance company, HMO, PPO, managed care company, governmental agency or other third party that my be responsible in whole or in part for the payment of my medical bills. A copy of this release is as valid as an original.

Salina Regional Health Center Cancer Registry: I herby give permission to Salina Urology Associates, P.A., to provide the Salina Regional Health Center Cancer Registry with: (1) my name, address, date of birth, social security number, race, spouse name or next of kin: (2) any diagnosis of cancer, treatment or lifetime follow-up including physician consultation by telephone, mail or office visits; and (3) all pathology reports pertaining to the diagnosis of cancer. I understand that the diagnosis of Cancer by allowing the above information to be compiled by Salina Regional Health Center Cancer Registry and the Kansas Cancer Registry. I understand that the release of this information may assist in the future with the diagnosis, treatment and cure of cancer in other persons.

Restrictions: I understand that the recipient of any of my medical information pursuant to this authorization may not use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Duration and Release: This authorization shall continue in effect unless specifically withdrawn by me, in writing, and delivered to Salina Urology Associates, P.A. I release and hold harmless Salina Urology Associates, P.A.., its physicians, employees, and agents from any liability or claims that I might have by reason of the disclosure of information released pursuant to this authorization.

Capacity: I attest that I have full legal capacity to execute this authorization and am mentally competent.

Patient Signature:____________________________________Date:__________________

Signature of Parent, Guardian, Conservator, or Other Legal Designee:

____Date:__________________

INSURANCE AUTHORIZATION

I hereby authorize ***Salina Urology Associates, P.A***. to complete any medical forms on myself or my dependents. I give my permission for ***Salina Urology Associates, P.A***. to release medical information to my insurance company about services performed in this office or at the hospital.

I understand that this authorization can be withdrawn at any time by my request. A photocopy of this authorization is as valid as the original.

SIGNATURE:_________________________________DATE:_____________________

I hereby authorize payment to be made directly to ***Salina Urology Associates, P.A***.

SIGNATURE:_________________________________DATE:_____________________