

**PATIENT INFORMATION:** SS#: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone# \_\_\_\_\_ Cell# \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work # \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

**Patient referral information: Your insurance company and Dr. Robinson require this information. Dr. Matthew Robinson utilizes this information to send information about your care to your Referring and primary care physician (if appropriate).**

Referring M.D. : \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Insurance Information: Please complete this section if the patient is not the primary cardholder for either the primary or secondary insurance. This information is required by the insurance company for identification of policyholder and correct billing.**

Primary Cardholders Name: \_\_\_\_\_

Primary Cardholders DOB: \_\_\_\_\_ Primary Cardholders SS#: \_\_\_\_\_

### Assignment and Release

I, the undersigned have insurance with \_\_\_\_\_ and assign directly to the Urology Place all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian \_\_\_\_\_

### Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to The Urology Place for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and patient is responsible only for deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Signature \_\_\_\_\_

# PATIENT HISTORY FORM

TODAY'S DATE \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

LAST NAME \_\_\_\_\_

FIRST NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_


Chief Complaint or the main reason for your visit today? (Describe your in detail)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## History of Present Illness (Please answer the following questions completely or write N/A)

<p><b>Location of the problem</b>                  Abdomen      Back      Leg                  Other _____                  _____                  _____</p>	<p>Front    Back</p> 	<p><b>Is anything else occurring at the same time?</b>                  YES    NO    If yes, please explain.                  Nausea    Rash    Headaches                  Other _____</p>
<p><b>AT ITS WORST.....</b>On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?                  1   2   3   4   5   6   7   8   9   10</p>	<p><b>Does anything make the problem better?</b>                  _____</p>	
<p><b>When did you first notice the problem?</b>                  2 days ago    2 weeks ago    1 month ago</p>	<p><b>Does anything make the problem worse?</b>                  _____</p>	
<p><b>How long does the problems last?</b> _____</p> <p><b>Is the problem constant or variable?</b>                  Dull then Sharp    Very sharp then leaves    Always there                  Other _____</p>	<p><b>Does the problem interfere with your normal functions?</b>                  Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain</p>	

MD ONLY: (COMMENTS/ NOTES)	<b># ANSWERS</b>	<b>LEVEL</b>
	1-3	1 OR 2
	4 +	3-5

## Past Medical, Family & Social History

(List all serious illnesses in your immediate family. Please fill in every box with information or N/A)

DISEASE	PARENTS	BROTHERS /SISTERS	CHILDREN	DISEASE	PARENTS	BROTHER/ SISTERS	CHILDREN	
DIABETES				BLEEDING				Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____
CANCER				KIDNEY PROBLEM				
HEART DISEASE				OTHER				Do you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____
HIGH BLOOD PRESSURE				OTHER				
								Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____
								Married: _____ # of Children: _____

<p><b>Past Illness and Dates</b></p> <table style="width: 100%;"> <tr> <th style="width: 70%;">Illnesses</th> <th style="width: 30%;">Date</th> </tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table>	Illnesses	Date	_____	_____	_____	_____	_____	_____	_____	_____	<p><b>Past Surgeries and Dates</b></p> <table style="width: 100%;"> <tr> <th style="width: 70%;">Surgeries</th> <th style="width: 30%;">Date</th> </tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </table>	Surgeries	Date	_____	_____	_____	_____	_____	_____	_____	_____	<p><b>Comments:</b></p> <p>_____</p>
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MD ONLY: (COMMENTS/ NOTES)	<b># ANSWERS</b>	<b>LEVEL</b>
	0	1 or 2
	1-2	3
	3	4 or 5

# Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Y**es or **N**o.

## Constitutional Symptoms

Fever Y N  
 Chills Y N  
 Headache Y N  
 Other \_\_\_\_\_

## Eyes

Blurred vision Y N  
 Double vision Y N  
 Pain Y N  
 Other \_\_\_\_\_

## Allergic/Immunologic

Hay Fever Y N  
 Drug allergies Y N  
 Other \_\_\_\_\_

## Neurological

Tremors Y N  
 Dizzy spells Y N  
 Numbness/tingling 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  
 Indigestion/heartburn Y N  
 Other \_\_\_\_\_

## Cardiovascular

Chest pain Y N  
 Varicose veins Y N  
 High blood pressure 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/Mouth

Ear infection Y N  
 Sore throat Y N  
 Sinus problem Y N  
 Other \_\_\_\_\_

## Genitourinary

Urine retention Y N  
 Painful urination Y N  
 Urinary frequency Y N  
 Other \_\_\_\_\_

## Respiratory

Wheezing Y N  
 Frequent cough Y N  
 Shortness of breath Y N  
 Other \_\_\_\_\_

## Hematologic/Lymphatic

Swollen glands Y N  
 Blood clotting problem Y N  
 Other \_\_\_\_\_

## Psychologic

Are you generally satisfied with your life? Y N  
 Do you feel severely depressed? Y N  
 Have you considered suicide? Y N  
 Other \_\_\_\_\_

Patient/family signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Physician use only: Comments/Notes</b>    	<table style="width: 100%; border: none;"> <tr> <td style="border: none;"><b># ANSWER</b></td> <td style="border: none;"><b>LEVEL</b></td> </tr> <tr> <td style="border: none;">0-1</td> <td style="border: none;">1 OR 2</td> </tr> <tr> <td style="border: none;">2-9</td> <td style="border: none;">3</td> </tr> <tr> <td style="border: none;">10+</td> <td style="border: none;">4 OR 5</td> </tr> <tr> <td colspan="2" style="border: none; text-align: center; margin-top: 10px;">Modified 5/6/02</td> </tr> </table>	<b># ANSWER</b>	<b>LEVEL</b>	0-1	1 OR 2	2-9	3	10+	4 OR 5	Modified 5/6/02	
<b># ANSWER</b>	<b>LEVEL</b>										
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2-9	3										
10+	4 OR 5										
Modified 5/6/02											

**XX MD SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

Home Telephone \_\_\_\_\_

O.K. to leave message with detailed information

Leave Message with call-back number only

Written Communication

O.K. to mail to my home address

O.K. to mail to my work/office address

O.K. to fax to this number

Work Telephone \_\_\_\_\_

O.K. to leave message with detailed information

Leave message with call-back number only

Other (Spouse, Children, Etc)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of , and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entitles must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

**Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

## Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Discription of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if the disclosure is authorized
- (2) Type key: T= Treatment Records; P= Payment Information; O= Healthcare Operations
- (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

## **Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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Signature of Patient or Personal Representative

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Date

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Name of Patient or Personal Representative

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Description of Personal Representative's Authority