PATIENT HISTORY FORM

Name: ____SSN:_____________________
(Last) (First) (MI)

DOB: _______________Age: ___________Male ______Female _____Marital Status__________

Address: ____
(Street) (City) (State) (Zip)
Home Phone:_____________________Cell:___________________Work:_______________________

Email Address:____

Preferred Method of Contact: Home ______Cell ______Work _____Email ______Text_______

Ethnicity: __________________________________Preferred Language: ____________________

Occupation: __________________________Employer:________________________________

Emergency Contact____Phone:_________________

Relationship:________________________________

Referring Doctor: ______________________________Primary Care DR: ____________________

CHIEF COMPLAINT: (Main reason for today's visit) ______________________________________

Date_______________________

 STICKER

PAST MEDICAL HISTORY

SURGICAL PROCEDURES: List all past surgical procedures and the year they were performed

____

____

MEDICAL ILLNESSES: Circle any of the following you are currently being treated for:

Asthma Cancer Diabetes Emphysema Heart Disease High Blood Pressure Seizures Stroke
Other:

____

____

DRUG ALLERGIES: List all medications you are allergic to and the type of reaction:

____

____

CURRENT MEDICATIONS: List all of your current medications. Include dose and directions.

____

____

____

____

____

PREFERRED PHARMACY: ____

PREFERRED LAB: We perform prostate screening labs and low testosterone related labs in-house. Some other labs may be sent **to LabCorp, BSA, NWTH** or **Quest.** If you or your insurance prefers a different outside lab please notify the clinical staff assisting you and a written order form will be given to you to take to the lab of your choice.

 STICKER

FAMILY HISTORY

Father: Age living _____ Age deceased _____ Medical Illnesses: __________________________

Mother: Age living _____Age deceased _____ Medical Illnesses: __________________________

Brothers: How many _____ Ages Living __________________Ages deceased _______________

Medical Illnesses ____

Sisters: How many _____ Ages Living ___________________ Ages deceased ______________

Medical Illnesses ____

PREVENTATIVE CARE

Do you currently use tobacco products? YES _____ NO _____ If yes, what type of tobacco:

Cigarettes _____ Cigars _____ chewing tobacco/snuff _____ other _______

If no, did you ever: YES _____ NO _____ When did you stop: ________________________

Do you drink alcohol? YES _____ NO _____ What type and how much: _____________________

Have you had a flu shot? YES _____ NO _____ When: ________________________

Pneumonia shot? YES _____NO _____ When: ___________________________

Patients age 50 and older: Have you had a colonoscopy? YES _____NO _____ YEAR __________

Patients age 65 and older: do you have an Advanced Care Plan (Living Will)? YES ____ NO _____

Have you had a bone density scan in the last 2 years? YES _____NO ______ YEAR___________

Is another provider managing your Vitamin D? YES _____NO _____

Provider ____________________________________

 STICKER

REVIEW OF SYSTEMS

Do you now have or have you had any problems related to the following areas:
Please explain any YES answers in the space provided.

Constitutional:

Fever	Y	N
Chills	Y	N
Lethargy	Y	N

Other ____________________

Ears/Nose/Throat/Mouth:

Ear Infection	Y	N
Sore Throat	Y	N
Sinus	Y	N

Other ____________________

Respiratory:

Wheezing	Y	N
Freq Cough	Y	N
Shortness of Breath	Y	N

Other ____________________

Genitourinary:

Urinary Retention	Y	N
Urinary Frequency	Y	N
Painful Urination	Y	N
Blood in Urine	Y	N

Other ____________________

Integumentary (Skin):

Skin Rash	Y	N
Breast Lumps	Y	N
Persistent Itch	Y	N

Other ____________________

Psychologic:

Sleep Disorder	Y	N
Depression	Y	N
Suicidal	Y	N

Hematologic/Lymphatic:

Swollen Glands	Y	N
Blood Clotting	Y	N

Other ____________________

Eyes:

Vision Change	Y	N
Glasses/Contacts	Y	N
Pain/Injury	Y	N

Other ____________________

Cardiovascular:

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N

Other ______________________

Gastrointestinal:

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigest/Heartburn	Y	N

Other ______________________

Musculoskeletal:

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Other _______________________

Neurologic:

Tremors	Y	N
Dizziness	Y	N
Numbness	Y	N

Other _______________________

Endocrine:

Excessive Thirst	Y	N
Coldness	Y	N
Fatigue	Y	N

Immunologic (Allergy):

Sneezing	Y	N
Running Nose	Y	N

Other _______________________

STICKER

TESTOSTERONE QUESTIONAIRE

1. How would you rate your libido (sex drive)?
   1-terrible 2-poor 3-average 4-good 5-excellent
2. How would you rate your energy level?
   1-terrible 2-poor 3-average 4-good 5-excellent
3. How would you rate your strength/endurance?
   1-terrible 2-poor 3-average 4-good 5-excellent
4. How would you rate your enjoyment of life?
   1-terrible 2-poor 3-average 4-good 5-excellent
5. How would you rate your happiness level
   1-terrible 2-poor 3-average 4-good 5-excellent
6. How strong are your erections?
   1-terrible 2-poor 3-average 4-good 5-excellent
7. How would you rate your work performance over the past 4 weeks?
   1-terrible 2-poor 3-average 4-good 5-excellent
8. How often do you fall asleep immediately after dinner?
   (1=problem, 5=not a problem)
   1-terrible 2-poor 3-average 4-good 5-excellent
9. How would you rate your sports ability over the past 4 weeks?
   1-terrible 2-poor 3-average 4-good 5-excellent
10. How much height have you lost?
    1-(2" or more) 2-(1.5"-1.9") 3-(1"-1.4") 4-(0.5"-0.9") 5-(none-0.4")

TOTAL SCORE ______________

11. Do you have trouble sleeping? ____Yes ____No

STICKER

Patient Consent

I consent to treatment necessary for the care of named patient.

I acknowledge full financial responsibility for services rendered by Amarillo Urology Associates, L.L.P.

I understand that payment of charges is due at the time of service unless other arrangements have been made prior to treatment.

I authorize release of information to my insurance company in order to process claims and authorize payment to be made to Amarillo Urology Associates, L.L.P.

I authorize release of my medical information to any other facility that I am referred to by this office.

I authorize the use of my photo as part of my permanent medical record.

I understand there may be times I am asked to see a mid-level practitioner at Amarillo Urology Associates. I consent to have the services of a Physician Assistant/Nurse Practitioner for my healthcare needs.

*I have read and understand the **Patient Consent** and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.*

_______________________________________ ______________________

Signature of Patient or Responsible Party for Minor *Date*

____

Printed Name of Patient

STICKER

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with the business manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, Discover and American Express.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided. Any balance due is your responsibility and is due upon receipt of a statement from our office.

No Insurance – Self Pay Discount

- A patient with no insurance will be required to make a deposit of $400 prior to seeing a doctor and will be billed the remaining amount due or receive a refund check if the $400 represents an overpayment.
- A patient who has no insurance will automatically receive a 25% discount off of billed charges. The 25% uninsured discount is not contingent upon payment time frame.

Lab Work

- For all Lab Work performed at Amarillo Urology Associates, L.L.P., it is the patient's responsibility to notify Amarillo Urology Associates, L.L.P., where your health plan dictates your work be sent.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend this and it is in effect until changed.

____ Date ________________________________
Signature of Patient or Responsible Party of Minor

STICKER

NOTICE OF PRIVACY PRACTICES

I have been informed that Amarillo Urology Associates, L.L.P. has a Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that upon request, I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

____

Date

____

Patient or Personal Representative (Printed)

____

Personal Representative Relationship to Patient (Printed)

I authorize that my medical information can be released as follows:

Information to be released to:

____

Name/Relationship to Patient (Printed)

____

Signature of Patient

Information to be released to:

____

Name/Relationship to Patient

____

Signature of Patient

Date ___________________________

STICKER

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **Amarillo Urology Associates, L.L.P.** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount assigned by your insurance provider as “patient responsibility”.

Authorization to Release Information

I hereby authorize **Amarillo Urology Associates, L.L. P.** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from **Amarillo Urology Associates, L.L. P.** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

____ ____________________________________

Patient/Responsible Party Signature Date

____ ____________________________________

Witness Date

STICKER