COASTAL
UROLOGY
ASSOCIATES. P.A.

PATIENT INFORMATION

Name_____ SS#_____
FIRST MI LAST

Race _____ Ethnicity_____ Preferred language_____

Mailing Address:_____ City_____

State_____ Zip_____ Date of Birth_____ Male _____ Female____

Home Phone(____)_____ Work Phone(____)_____

Cell Phone (____)_____ e-mail _____

Please check appropriate space: Minor____ Single____ Married____ Widowed____ Divorced____

Patient's or Parent's Employer_____

Business Address_____

Spouse or Parent's Name_____

Are you, parent or spouse currently an active member of the military? Yes____ No____ If yes please indicate name, relationship, branch of service_____

Whom may we "thank" for sending you?_____

Allergies_____
DRUGS - FOODS

Person to contact in case of emergency_____

Relationship_____Phone(____) _____

RESPONSIBLE PARTY

Person responsible for this account_____Relationship_____

Employer_____Phone(____)_____

Birthdate_____ SS# _____Work Phone(____)_____

INSURANCE INFORMATION

Please give your ***insurance cards*** to our staff so we may make a copy of them.

PRIMARY INSURANCE

Company_____

Insurance Company Address_____

Name of Insured_____ Relationship to Insured_____

SS# of Insured_____ID#_____Group_____

How much is your deductible? _____ Insured date of birth?_____

Primary Physician_____ Is this a managed care program (HMO)? Yes___No___

Primary Physicians Address_____

Primary Physicians Phone ( )_____ Group Name_____

Pharmacy Name_____ Phone (___) _____

Pharmacy Address_____

SECONDARY INSURANCE

Company_____

Insurance Company Address_____

Name of Insured_____ Relationship to Insured_____

SS# of Insured_____ ID#_____ Group_____

Name of Employer_____ Phone(___)_____

How much is your deductible? _____ Insured date of birth?_____

Primary Physician_____ Is this a managed care program (HMO)? Yes___No___

Primary Physicians Address_____

Primary Physicians Phone (_____)_____ Group Name_____

TO OUR PATIENTS:

Our office will attempt to assist you with the completion of your insurance claim. However, each patient, not the insurance company, is responsible for payment to this office. Our office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim.

Due to the increasing complexity of insurance policies with regard to PRE-CERTIFICATION, ASSISTANT SURGEON, SECOND OPINIONS, etc., for hospital stays and operations, **YOU ARE RESPONSIBLE** for notifying your insurance company before being admitted to the hospital. This will help avoid unnecessary denials or lowering of payment for failing to follow the OBLIGATIONS of YOUR POLICY.

We cannot be responsible for any loss of benefits. It is **YOUR RESPONSIBILITY TO KNOW YOUR POLICY.**

Authorization & Release

I, the undersigned hereby authorize payment of medical benefits to COASTAL UROLOGY ASSOCIATES, P.A. for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract.

I authorize release of information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

X_____

Signature of patient (or parent if minor) Date

MEDICARE LIFETIME SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made on my behalf to COASTAL UROLOGY ASSOCIATES, P.A. for any services furnished me by the physician. 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 or benefits payable for related services.

X_____

Signature PHOTO COPY AS VALID AS ORIGINAL Date

COASTAL
UROLOGY
ASSOCIATES, P.A.

PATIENT HISTORY

WELCOME TO OUR PRACTICE

As a new patient, please fill out the information found below to the best of your ability. A few minutes of your time carefully answering the following questions will help our urologist accurately access your problem, give better care and assist in proper insurance submission.

Patient#_____ Physician_____ Today's Date_____

Patient Name_____ Age_____ Date of Birth_____

Chief Complaint (reason for visit)_____

HISTORY OF PRESENT ILLNESS

Location_____ Quality_____
(Where is problem or pain?) (Example abnormal color, sharp, dull or constant, etc.)

Severity_____ Duration_____
(How severe is problem or pain on a scale of 1-10, 10 being the most severe) (When did problem or pain start?)

Timing_____ Context_____
(Does problem or pain occur at a specific time?after activity,eating,etc.) (Where & what were you doing at onset of problem or pain?)

Associated Signs & Symptoms_____ Modifying Factors_____

_____ _____
(What other associated problems have you been having?) (What makes problem or pain worse or better?)

PATIENT MEDICAL & SOCIAL HISTORY

PATIENT MEDICAL HISTORY: Have you ever had the following (circle "yes" or "no", leave blank if uncertain):

Measles	Yes No	Arthritis	Yes No	Mitral Valve Prolapse	Yes No	Blood or Plasma	
Mumps	Yes No	Venereal Disease	Yes No	Hernia	Yes No	Transfusions	Yes No
ChickenPox	Yes No	Anemia	Yes No	Asthma	Yes No	High or Low	
Whooping Cough	Yes No	Bladder Infection	Yes No	AIDS or HIV+	Yes No	Blood Pressure	Yes No
Scarlet Fever	Yes No	Epilepsy	Yes No	Stroke	Yes No	**ANY OTHER DISEASES (please list)**	
Diphtheria	Yes No	Hepatitis	Yes No	Ulcer	Yes No	_____	
Smallpox	Yes No	Tuberculosis	Yes No	Thyroid Disease	Yes No	_____	
Pneumonia	Yes No	Diabetes	Yes No	Kidney Disease	Yes No	_____	
Rheumatic fever	Yes No	Cancer	Yes No	**DATE OF LAST CHEST**		**DATE OF LAST MAMMOGRAM** (female)	
Heart Disease	Yes No	Polio	Yes No	**X-RAY**_____		_____	

Do you have any artificial joints, heart valves, heart pacemaker or defibrillator?_____

MEDICATIONS: *(Include prescription, nonprescription and dosages)* _____

_____ _____ _____

_____ _____ _____

ALLERGIES: *(Include allergies to medication, Iodine, X-ray contrast material, shellfish, etc.)*_____

_____

PAST SURGERY: (Include date of surgery)_____

_____

_____

PATIENT SOCIAL HISTORY:

Marital status: Single:_____ Married:_____ Separated:_____ Divorced:_____ Widowed:_____
Use of Alcohol: Never:_____ Rarely:_____ Moderate:_____ Daily:_____
Use of Tobacco: Never:_____ Previously, but quit_____ Current packs/day:_____
Use of Drugs Never:_____ Type/Frequency _____

What is your occupation? (If retired, what was it prior to retirement?)_____

FAMILY MEDICAL HISTORY:

	AGE	DISEASE(s)	IF DECEASED CAUSE OF DEATH
Father			
Mother			
Siblings			
Spouse			
Children			

REVIEW OF SYSTEMS

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

Constitutional Symptoms
- Fever Yes No
- Chills Yes No
- Headache Yes No
- Other _____

Eyes
- Blurred vision Yes No
- Double vision Yes No
- Pain Yes No
- Other _____

Allergic/Immunologic
- Hay Fever Yes No
- Drug Allergies Yes No
- Other_____

Neurological
- Tremors Yes No
- Dizzy spells Yes No
- Numbness/tingling Yes No
- Other_____

Endocrine
- Excessive thirst Yes No
- Too hot/cold Yes No
- Tired/sluggish Yes No
- Other_____

Gastrointestinal
- Abdominal pain Yes No
- Nausea/vomiting Yes No
- Indigestion/heartburn Yes No
- Other_____

Cardiovascular
- Chest pain Yes No
- Varicose veins Yes No
- High blood pressure Yes No
- Other_____

Integumentary
- Skin rash Yes No
- Boils Yes No
- Persistent itch Yes No
- Other_____

Musculoskeletal
- Joint pain Yes No
- Neck pain Yes No
- Back pain Yes No
- Other_____

Ear/Nose/Throat/Mouth
- Ear infection Yes No
- Sore throat Yes No
- Sinus Problem Yes No
- Other_____

Genitourinary
- Urine retention Yes No
- Painful urination Yes No
- Urinary frequency Yes No
- Other_____

Respiratory
- Wheezing Yes No
- Frequent cough Yes No
- Shortness of breath Yes No
- Other_____

Hematologic/Lymphatic
- Swollen glands Yes No
- Blood clotting problem Yes No
- Other_____

Psychologic
- Memory loss/confusion Yes No
- Anxiety Yes No
- Depression Yes No
- Other_____

I authorize release of information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims of insurance benefits.

X _____
Patient (or Guardian) Signature Date

ASSURANCE OF PRIVACY FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem or improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We realize there is always room for improvement! It is our policy to listen to our employees and our patients. If you feel your privacy has been compromised in any way, please ask to speak with our compliance officer or express your concern to your physician.

Please read the following "Notice of Privacy." After reading, sign and return this form to the receptionist. If you have any questions, please ask. Thank you.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that the personal health information (PHI) is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing patient health information that is needed to carry out proper treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum amount of necessary information to only those we feel are in need of your health care information. **We strive to provide the best health care that is in <u>your</u> best interest.**

We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties you do not want PHI released to please tell our compliance officer and it will be documented in your chart. If there is any party that is not directly connected to your treatment, payment, or health care operations that you would like to have your PHI released to, please fill in their name(s) and relationship in the section below.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our compliance officer. You have the right to review our entire privacy policy manual upon request. Please sign this form to acknowledge that you have read this patient notice of privacy.

<u>Persons authorized to receive information</u>

_____ Relationship_____

_____ Relationship_____

Patient Name: _____

Signature: _____ Date: _____

If minor, signature of parent or guardian: _____

Thank you for being one of our highly valued patients.

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<u>For office use only</u>

A "good faith effort" was made to get a signature from patient, guardian, caretaker. Signature was not attained due to the following: _____

_____

Please refrain from using ANY

Perfume & Cologne

When visiting our office since our Doctor is

HIGHLY Allergic