A picture containing food

Description automatically generated

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Patient’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Marital Status: \_\_\_\_\_\_\_\_\_\_ Spouse’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Name and Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party (If not Patient)**

Person responsible for bill: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient History**

Why are you seeing the doctor today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** (Please list ALL): (NONE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Past Medical History** (Please Check if you have had any of the following):

**Cardiovascular**

Anemia

Angina (Chest pain)

Aortic Aneurysm

Irregular heartbeat

Atrial Fibrillation

Bleeding Disorder

Cerebrovascular Disease / Stroke

Congestive Heart Failure

Coronary Artery Disease

Deep Vein Thrombosis (Blood clots)

Heart Attack

Heart Murmur

Heart Valve Problem / Replacement

Hypertension (High Blood Pressure)

Mitral Valve Prolapse

Sickle Cell Anemia

Thrombophlebitis

**Endocrine/Metabolic**

Diabetes (Non-Insulin Dependent)

Diabetes (Insulin Dependent)

Gout

Hyperthyroidism (High)

Hypothyroidism (Low)

**General**

Allergies

Hernia Location: \_\_\_\_\_\_

High Cholesterol

Malaise (Weak / Tired)

Sleep Apnea

**GI**

Cholelithiasis (Gallstones)

Colitis

Constipation

Crohn’s Disease

Diarrhea

Divericulosis

GERD (Acid Reflux, Indigestion)

Hemorrhoids

Hepatitis

Inflammatory Bowel Disease

Peptic Ulcer

Ulcerative Colitis

**GU**

HIV or AIDS

Bladder Stone

Bladder Infection (UTI)

Chronic Renal Insufficiency

Erectile Dysfunction

Hematuria (Blood in the Urine)

Interstitial Cystitis

Radiation Therapy

Kidney Infection

Kidney Stones

Neurogenic Bladder

Orchitis (Testicle Infection)

Polycystic Kidney Disease

Recurrent UTI

Undescended Testicle

**Gynecology/Obstetrics**

Endometriosis

Menopause

Osteoporosis

Uterine Fibroids

**ENT**

Blindness

Cataracts

Glaucoma

Mumps

**Musculoskeletal**

Arthritis

Back Pain

Fibromyalgia

**Neurology/Psychiatric**

Alcoholism

Alzheimer’s Disease

Anxiety

Bipolar Disorder

Chronic Fatigue Syndrome

Depression

Epilepsy

Migraine

Multiple Sclerosis

Parkinson’s Disease

Spinal Cord Injury

Stroke

**Respiratory**

Asthma

Bronchitis

Emphysema (COPD)

Pneumonia

Pulmonary Embolism

Tuberculosis (TB)

**Oncology**

Bladder Tumor

Brain Tumor

Breast Cancer

Cervical Cancer

Colon Cancer

Lung Cancer

Lymphoma

Melanoma

Ovarian Cancer

Prostate Cancer

Kidney Cancer

Testicular Cancer

**Initial Here if you have no Medical Problems:** \_\_\_\_\_\_\_\_\_\_\_\_

**Please List any other Diseases or Conditions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

**Past Surgical History** (Please Check if you have had any of the following and indicate the year of surgery):

**Cardiovascular**

\_\_\_\_\_\_\_Angioplasty

\_\_\_\_\_\_\_Aortic Aneurysm Repair

\_\_\_\_\_\_\_CABG

\_\_\_\_\_\_\_Carotid Artery Surgery

\_\_\_\_\_\_\_Heart Stents

\_\_\_\_\_\_\_Heart Transplant

\_\_\_\_\_\_\_Pacemaker

\_\_\_\_\_\_\_Artificial Heart Valve

**GI**

\_\_\_\_\_\_\_Appendectomy

\_\_\_\_\_\_\_Weight Loss Surgery

\_\_\_\_\_\_\_Bowel Resection

\_\_\_\_\_\_\_Gall Bladder Removal

\_\_\_\_\_\_\_Colon Resection

\_\_\_\_\_\_\_Colonoscopy

\_\_\_\_\_\_\_EGD

\_\_\_\_\_\_\_Fissurectomy

\_\_\_\_\_\_\_Hemorrhoidectomy

\_\_\_\_\_\_\_Ileostomy

\_\_\_\_\_\_\_Inguinal Hernia

\_\_\_\_\_\_\_Laparoscopy

\_\_\_\_\_\_\_Liver Surgery

\_\_\_\_\_\_\_Lysis of Adhesions

\_\_\_\_\_\_\_Splenectomy

\_\_\_\_\_\_\_Umbilical Hernia Repair

\_\_\_\_\_\_\_Ventral Hernia Repair

**Urologic**

\_\_\_\_\_\_\_Bladder Surgery

\_\_\_\_\_\_\_Prostate Biopsy

\_\_\_\_\_\_\_Brachytherapy (Seed Implant)

\_\_\_\_\_\_\_Circumcision

\_\_\_\_\_\_\_Cystoscopy

\_\_\_\_\_\_\_Urethral Dilation

\_\_\_\_\_\_\_Ureteral Stent Placement

\_\_\_\_\_\_\_Epididymectomy

\_\_\_\_\_\_\_ESWL (Shockwave Stones)

\_\_\_\_\_\_\_Hydrocelectomy

\_\_\_\_\_\_\_Ileal Conduit

\_\_\_\_\_\_\_Interstim

\_\_\_\_\_\_\_Laser Kidney Stone Surgery

\_\_\_\_\_\_\_Kidney Removal

\_\_\_\_\_\_\_Nephrolithotomy

\_\_\_\_\_\_\_Testicle Removal

\_\_\_\_\_\_\_Penile Implant / Prosthesis

\_\_\_\_\_\_\_Penectomy

\_\_\_\_\_\_\_Pyeloplasty

\_\_\_\_\_\_\_Prostate Removal for Cancer

\_\_\_\_\_\_\_Kidney Transplant

\_\_\_\_\_\_\_Spermatocelectomy

\_\_\_\_\_\_\_Prostate Microwave

\_\_\_\_\_\_\_Urolift

\_\_\_\_\_\_\_Laser Surgery on Prostate

\_\_\_\_\_\_\_TURP

\_\_\_\_\_\_\_Bladder Tumor Removal

\_\_\_\_\_\_\_Varicocelectomy

\_\_\_\_\_\_\_Vasectomy

**Gynecology**

\_\_\_\_\_\_\_C-Section

\_\_\_\_\_\_\_Hysterectomy

\_\_\_\_\_\_\_Removal of Ovaries

\_\_\_\_\_\_\_Tubal Ligation

**ENT**

\_\_\_\_\_\_\_Cataract Surgery

\_\_\_\_\_\_\_Eye Surgery

\_\_\_\_\_\_\_Facial Surgery

\_\_\_\_\_\_\_Nasal Surgery

\_\_\_\_\_\_\_Sinus Surgery

\_\_\_\_\_\_\_Tonsil Surgery

\_\_\_\_\_\_\_Thyroid Surgery

\_\_\_\_\_\_\_Parathyroid Surgery

**Musculoskeletal**

\_\_\_\_\_\_\_Amputation

\_\_\_\_\_\_\_Knee Surgery

\_\_\_\_\_\_\_Carpal Tunnel Surgery

\_\_\_\_\_\_\_Neck Surgery

\_\_\_\_\_\_\_Foot Surgery

\_\_\_\_\_\_\_Hand Surgery

\_\_\_\_\_\_\_Hip Surgery

\_\_\_\_\_\_\_Leg Surgery

\_\_\_\_\_\_\_Shoulder Surgery

\_\_\_\_\_\_\_Spine Surgery

\_\_\_\_\_\_\_Back Surgery

\_\_\_\_\_\_\_Disc Surgery

**Respiratory**

\_\_\_\_\_\_\_Lung Surgery

**Skin**

\_\_\_\_\_\_\_Basal Cell Carcinoma

\_\_\_\_\_\_\_Melanoma

\_\_\_\_\_\_\_Squamous Cell Carcinoma

\_\_\_\_\_\_\_Pilonidal cyst

\_\_\_\_\_\_\_Skin Graft

**Initial Here if you have had no surgeries:** \_\_\_\_\_\_\_\_\_\_\_\_

**Please List any other surgeries and their dates:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

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

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

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

**Family History** (please indicate if any family members have had any of the following conditions):

Prostate Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Attack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bladder Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Stones \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Failure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Alcohol Consumption: None  Occasional/Social Number Drinks per Day: \_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use:  None Packs Per Day: \_\_\_\_\_\_\_ Cigarettes Per Day: \_\_\_\_\_\_  Smokeless Tobacco

If you previously smoked, when did you quit? \_\_\_\_\_\_ How many years did you smoke? \_\_\_\_\_\_ Packs per day? \_\_\_\_\_\_

Caffeinated Beverages: None 1-2 per day 3-4 per day 5 or more per day

Recent Foreign Travel: None Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecologic History:**

Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Vaginal Deliveries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:**

**Are you on any blood thinners (aspirin, Plavix, coumadin, warfarin, Eliquis, Xarelto)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name Dosage Directions/How you take it

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

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

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

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

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

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

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

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

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

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

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

**Review of Systems:**

Do you have any of the following symptoms?

**General**

Fever

Chills

Sweats

Weakness

Malaise

Abnormal Weight Loss

Sleep Disturbance

**ENT**

Double Vision

Blurred Vision

Eye Irritation

Eye Discharge

Vision Loss

Eye Pain

Light Sensitivity

Earache

Ringing in Ears

Nasal Congestion

Nosebleeds

Sore Throat

Difficulty Swallowing

Hearing Loss

**Cardiac**

Chest Discomfort

Chest Pain

Palpitations

Fainting

Numbness in Arms

Swelling of Limbs

**Respiratory**

Cough

Shortness of Breath

Wheezing

Chest Congestion

Asthma

**Gastrointestinal**

Nausea

Vomiting

Diarrhea

Constipation

Abdominal Pain

Blood in Stool

Heartburn

**Genitourinary**

Painful Urination

Blood in Urine

Urinary Frequency

Urinary Hesitancy

Incontinence

**Musculoskeletal**

Back Pain

Joint Pain

Joint Swelling

Muscle Soreness

Arthritis

**Skin**

Sensation Disturbance

Bruising

Rash

Itching

Dryness

Suspicious lesions

**Neurological**

Headaches

Memory Loss

Confusion

Transient Paralysis

Weakness

Numbness

Tingling

History of Seizures

Tremors

Dizziness

**Psychiatric**

Depression

Anxiety

Memory Loss

Mental Disturbances

Suicidal Thoughts

Mood Disorders

Paranoia

Sleep Disturbances

Eating Disorder

**Endocrine**

Sensitivity to Cold

Sensitivity to Heat

Abnormal Weight Gain

Excessive Thirst

Excessive Urination

Excessive Hunger

Diabetes

**Hematologic / Lymphatic**

Chronic Infections

Abnormal Bruising

Bleeding

Enlarged Lymph Nodes

**Allergic / Immunologic**

Hives

Hay Fever

Persistent Infections

HIV Exposure

Runny Nose

Sinus Congestion

**Extremities**

Redness of a Limb

Swelling of a Limb

Discoloration of a Limb

A picture containing food

Description automatically generated

**GENERAL CONSENT FOR TREATMENT**

I have voluntarily sought treatment for a specific illness or condition requiring diagnostic, medical, or surgical procedures. I hereby do voluntarily consent to such procedures and care and to such medical, surgical, or other services under the general and specific instructions of Dr. Darren Chapman, his assistants, or his designee as is necessary in his judgement.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination.

**POLICY EXCLUSIONS**

I understand there is a possibility that there are diagnosis exclusions: services that insurance companies will not pay for. Examples are, but are not limited to, erectile dysfunction and infertility. If I am being seen for an excluded diagnosis, I understand that I will be responsible for payment in full

**RELEASE OF MEDICAL INFORMATION**

I hereby authorize Dr. Darren Chapman to furnish treatment to me and to release information to the insurance carriers concerning my illness, and I do hereby irrevocably assign to the doctor all payment for medical services rendered. I understand that I am financially responsible for charges whether or not covered by insurance.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of Pearland Urology Notice of Privacy Practices.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION**

1. Please list the family members or other persons, if any, whom we may inform about:
   1. Your general medical condition and your diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Your medical condition ONLY IN AN EMERGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Your FINANCIAL INFORMATION ONLY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Can confidential messages (i.e. Appointment reminders) be left on your home answering machine or voicemail? (Yes/No) \_\_\_\_\_\_\_\_\_\_
3. If you do not have voicemail, can a confidential message be left at your place of employment? (Yes/No) \_\_\_\_
4. Can confidential messages (i.e. Appointment reminders) be sent via e-mail? (Yes/No) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

I have an Advanced Directive on file: Yes or No I have a Medical Power of Attorney on file: Yes or No

A picture containing food

Description automatically generated

**Vasectomy Cancellation/Reschedule Policy**

At Pearland Urology, we understand that sometimes life gets in the way of getting your vasectomy. We ask that you give us **1 weeks’ notice** prior to your scheduled procedure to cancel or reschedule. **If you give us 1 weeks’ notice, you may cancel or reschedule without any consequences**.

We do not charge a fee or penalty for failing to give us 1 weeks’ notice to cancel or reschedule your procedure.

However, if you do not give us 1 weeks’ notice, we do require a **$200 deposit** to put you back on the vasectomy schedule. **This $200 deposit will be returned to you if you then proceed to have your vasectomy done at the rescheduled date and time**.

Please note – **this is important!** – once you place your deposit and you are back on the schedule, **your date and time are not allowed to be changed again for any reason**. This includes medical emergencies and Acts of God. If you miss your appointment for your procedure, you will forfeit your $200 deposit and **we will not put you back on the schedule again**. You will have to go somewhere else for your vasectomy. Please note that “missing your appointment” includes arriving more than 20 minutes late for your procedure.

**By signing below, you agree that you understand and will abide by this policy**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A picture containing food

Description automatically generated

Insurance Payment Policy

Unfortunately, we have recently seen a significant rise in our number of unpaid insurance claims.

Before we provide medical services to a patient, we contact that patient’s insurance company to get a quote for the patient to let him know how much it will cost. Recently, we have been receiving incorrect information from insurance companies. The insurance companies will deny the bill for the rendered services, despite previously informing us that they would pay it. This has led to “surprise bills” for patients that in most instances have gone unpaid.

Because of the insurance companies’ new game of “retroactively denying claims,” Pearland Urology has been forced to put in place a credit card hold policy. We will keep the patient’s credit card information on file, and, should the patient’s insurance company deny payment, we will charge the patient’s credit card for the services rendered.

Please read and sign the following agreement:

Patient Statement:

“I understand that Dr. Chapman’s office has contacted my insurance company on my behalf to get a quote for my health care services. I understand that sometimes these quotes provided by my insurance company are inaccurate. I agree that should my insurance company not remit complete payment of the contracted rate for my health care services to Dr. Chapman, then Dr. Chapman has my authorization to charge my credit card for any balance from this date forward, until I revoke the authorization in writing. I allow Dr. Chapman to keep my credit card information on file for this purpose.”

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_