Pearland UROLOGY

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

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:
    a. Your general medical condition and your diagnosis: _____
    b. Your medical condition ONLY IN AN EMERGENCY: _____
    c. 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

Drug Pre-Authorization Policy

As your physician I strive to give you the best possible treatment recommendations and prescribe the most suitable medications to treat your condition. Prescribing medication is a complex task which involves looking at the risk versus the benefit and taking into consideration your overall health and your other medications.

Recently, we have been bombarded with requests for "Pre-Authorization" of medications. Simply put, this is an attempt by your prescription insurance not to pay for medications which have been prescribed. This "Pre-Authorization" process is very time consuming for my staff and me, and many times, despite our best efforts, the insurance company still denies the medications I prescribe.

Insurance companies have limited formularies to save money. They also change their formulary year to year, so what may be covered one year may not be covered the next.

Because of the significant time and effort involved in trying to convince your insurance company to allow you to have the medications I prescribed, we must charge a fee of $30 to try to cover the overhead associated with this task. This fee is due in advance and is non-refundable. We will try to get the authorization for you. Please keep in mind, however, that your insurance carrier may still deny the request.

What are your other options?

1. You may pay for the medication out of pocket. There are websites such as GoodRx.com that offer many medications at discount prices.
2. You may change your prescription insurance coverage to a plan that will cover the medication.
3. You may bring a copy of your drug formulary so that I can see if there is an appropriate substitute or alternative to the drug I have prescribed.

We are here to assist you, answer your questions, and work with you to make your experience as pleasant, efficient, and beneficial as possible. Please understand that the entire "pre-authorization" process is an artificial roadblock put up by your insurance company and is outside of my control.

Thank you,
Darren Chapman, MD

I have read and understand the Pearland Urology Drug Pre-Authorization Policy.

Name: _____ Signature: _____ Date: _____

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: _____