PHOENIX UROLOGY

Name: _____ Social Security Number: _____
First MI Last

Date of Birth:_____M ____F ____Marital Status: _____Student: _____

Mailing Address: _____ City:_____

State: _____Zip Code: _____Home Phone: _____Cell Phone: _____

Email Address: _____ Notification Preference: Phone ___ Email___ US Mail___

Employer: _____Occupation:_____

Employer's Address: _____Employer's Phone:_____
City State Zip

Primary Care Physician (PCP):_____**Referring Physician:**_____

SPOUSE/GUARDIAN/DPOA INFORMATION:

Relationship to Patient: _____
(It is the policy of Phoenix Urology and Mercury that the parent that requests treatment for the minor child is responsible for all fees)

Name: _____Social Security Number:_____
First MI Last

Date of Birth_____M ____F ____Marital Status: _____Student: _____

Mailing Address: _____ City:_____

State: _____Zip Code: _____Home Phone: _____Cell Phone: _____

Employer: _____Occupation:_____

Employer's Address: _____Employer's Phone: _____
City State Zip

Patient Signature: _____ Date: _____

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date _____

Last Name _____ First Name _____ Date of Birth _____

Pharmacy _____ Primary Dr: _____ Referring Dr: _____

WHY ARE YOU HERE?

_____

_____

_____

Patient Height _____ Patient Weight _____

PAST MEDICAL & SOCIAL HISTORY

1.) List all your medical conditions. (Example: diabetes, tuberculosis, prostate cancer, heart disease, etc.)

_____

_____

_____

_____

_____

2.) List any personal surgeries and when occurred. Colonoscopy? Y N (if so when) _____

_____

_____

_____

_____

_____

3.) Are you on any medications? Y N (if yes, list all)

*****We are not part of Mosaic's system, please provide a current list of medications*****

_____

_____

_____

_____

_____

4.) Do you have allergies? Y N (if yes, list all and explain)

_____

_____

_____

5.) Tobacco use? Y N (if yes, how much) _____ previous use _____

Alcohol use? Y N (if yes, how much) _____

6.) List family medical conditions (Example: prostate cancer, bladder cancer, diabetes)

_____

_____

_____

REVIEW OF SYSTEMS

Do you now or have you had problems related to the following systems? Circle Y or N
Please explain any Yes answers in space provided

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 problems 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 Y N
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 _____

Physician use only: (Comments/Notes)

//Answer	Level of Service
0	1 or 2
1-2	3
3	4 or 5

Signature _____ Date _____

PHOENIX UROLOGY
GENERAL CONSENT TO TREAT

1. **Consent to Treatment.** I consent to and authorize medical treatment, diagnostic procedures, tests and examinations that are ordered by the physician. This consent remains in effect for the purpose of providing continuing and future medical care and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to result of treatments of examinations.
2. **Authorization to Release Information.** I authorize Phoenix Urology of St Joseph to disclose and release any medical information or record of the patient to any health care professional or facility, insurance company, governmental organization or regulatory agency, or third party payor for further medical care and treatment, certification and payment of medical expenses, and discharge planning
3. **Financial Responsibility.** I promise to pay Phoenix Urology of St Joseph for all costs and charges incurred or made for or on account of the patient. I understand that I am responsible for filing and collecting insurance in a timely and accurate manner, and resolving disputed insurance or third- party payor claims. I agree that this duty and responsibility is not being assumed by the health care providers. Estimate of patient financial responsibility is due prior to or at the time of service. Payment of the balance is due when billed by Phoenix Urology. If payment is not made when due, interest will accrue as provided by law. I agree to pay any and all costs of collection, including reasonable attorney' fees and expenses. I hereby expressly consent Phoenix Urology or its billing and collection agent(s) to contact me using electronic media to include; cell phone, auto messaging, text messaging and email.
4. **Assignment of Insurance and Other Benefit.** I hereby assign to Phoenix Urology health care providers all insurance and other health care coverage benefits otherwise payable, or to become payable, to or on behalf of patient.
5. **Medicare/Medicaid/Tricare Certification, Authorization and Assignment.** If eligible, I authorize Phoenix Urology to apply for benefits from, and submit claims directly to, Medicare, Medicaid or Tricare on behalf of patient, and certify that the information given in applying for payment is correct. I hereby assign to Phoenix Urology health care providers all Medicare, Medicaid or Tricare benefits payable, or to become payable, to or on behalf of patient. I understand that if services are not covered, are not paid, or do not qualify for payment, I will be responsible for payment incurred charges, and/or, deductibles and patient's portion of qualified covered charges.

I hearby request this practice to release and disclose the health care information contained in my medical record:
To the following person person(s) or entity:

Name	Relationship	Date of Birth

*I understand that I have the right to terminate this request either verbally or in writing.
*I understand that information used tor disclosed pursuant to this authorization may be disclosed by recipient and may no longer be protected by federal or state law.
*I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATIONS AND I UNDERSTAND THAT MY SIGNATURE PERTAINS TO EACH OF THEM.

_____ _____
PATIENT SIGNATURE **DATE** **OTHER SIGNATURE**

_____ _____
DATE OF BIRTH **RELATIONSHIP TO PATIENT**

EMAIL ADDRESS: _____

DPOA : _____