

NEW PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION										
Last Name		First Name			Middle Initial					
Address		Apt #		City/State/Zip						
Home Tel #		Work Tel #		Ext./Dept.						
Date Of Birth		Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status					
Social Security #		Email Address:								
Patient Employer										
Employer Address										
Spouse's Name		Date of Birth		Spouse's SSN						
Spouse's Employer		Spouse's Work Phone								
Employer Address										
Who is your Primary Care Doctor?										
Who referred you to our office?										
If referred by a doctor, Dr. Address:						Phone #				
Person to contact in case of emergency (not living with you)						Phone #				
Responsible Party Last Name		First Name			Relation					
Address/City/State/Zip										
Telephone		Resp. Party SSN:								
INSURANCE INFORMATION										
<i>(Please provide copies of your cards and/or insurance forms)</i>										
1	First Insurance Name									
	Policy Holder Last Name		First Name		Relationship					
	Certificate/ID #		Group Name/No.		Date of Birth					
	Is this insurance from an employer group? Y/N		If yes, Employer							
2	Second Insurance Name									
	Policy Holder Last Name		First Name		Relationship					
	Certificate/ID #		Group Name/No.		Date of Birth					
	Is this insurance from an employer group? Y/N		If yes, Employer							
ASSIGNMENT OF INSURANCE BENEFITS										
SIGNATURE	<p>I hereby authorize the attending physician to furnish my insurance carrier with all information which said insurance carrier may request concerning my illness or injury.</p> <p>I additionally assign to the attending physician all payments to which I am entitled for medical and/or surgical expenses relative to the services reported.</p> <p>This authorization is in effect until rescinded by me in writing. A photocopy of this authorization is as valid as the original.</p>									
	SIGNATURE (Patient or Parent/Legal Guardian if Patient is a Minor)						DATE			

OFFICE USE	Reviewed By	Cards Obtained	Coverage Verified	Comments
Acct. #				

PATIENT AUTHORIZATION AND AGREEMENT FORM

Patient: _____ SSN: _____

DISCLOSURE: Urology Specialists of Nevada is a for-profit professional corporation solely owned and providing medical services to the community.

I hereby authorize Urology Specialists of Nevada to furnish my insurance carrier with all information which said insurance carrier may request concerning my illness or injury and/or illness or injury of my dependent listed above.

I hereby assign to Urology Specialists of Nevada all payment to which I am entitled for medical and/or surgical expenses relative to the services reported, and I understand that I am financially responsible for charges not covered by my insurance company at the time of service.

I understand that Urology Specialists of Nevada bill the insurance as a courtesy to me. I agree to provide accurate and complete information in a timely manner.

I agree to respond to any additional information that the insurance company may request in a timely manner. And, I understand that if the payment of the claim is delayed more than 90 days from the date of service due to my lack of cooperation with the insurance company, the physician(s) reserve the right to collect the balance in full from me immediately.

I understand that all co-payments, co-insurances, deductibles and charges for items not covered by my insurance are payable at the time service is rendered. USON accepts cash, personal checks, Visa and MasterCard only.

I understand that certain lab tests will be sent to an outside laboratory that is not affiliated with this practice and I will be billed by the laboratory for those charges.

I understand that there is an additional charge of \$25.00 for any check that is returned by my bank for any reason. Unpaid returned checks will be sent to the District Attorney's office.

I understand that balances not paid within 90 days from the date of service will be referred to an outside collection agency, and I will be responsible for attorney's fees, collection expenses and interest. I also understand that this account will be listed with local and national credit bureaus.

BROKEN APPOINTMENT POLICY

NEW PATIENT \$100.00 ESTABLISHED PATIENT \$30.00

THESE FEES WILL BE CHARGED FOR BROKEN APPOINTMENTS UNLESS 48 HOURS NOTICE IS GIVEN.

A photocopy of this authorization is as valid as the original.

SIGNATURE _____ DATE _____

NEW PATIENT PACKET
PEDIATRIC UROLOGY PATIENT HISTORY

Today's Date: _____

Patient Name: _____ Pediatrician: _____

Nickname: _____ Date of Birth: _____ Gender: _____

Parent/Guardian Names: _____

Relationship, if not birth parents: _____

What is the reason for your child's visit? _____

When did the symptoms start? _____

List all medical problems (past and present) and the date when first occurred for your child:

1. _____
2. _____
3. _____
4. _____

List all of your child's current medications, dose, date started and what it is for:

1. _____
2. _____
3. _____
4. _____

List all your child's allergies to medications, food, or substance (include type of reaction):

1. _____ 3. _____
2. _____ 4. _____

FAMILY HISTORY:

What is the age and state of child's blood relatives? If deceased, what was there age at the time of death, and any other major medical conditions?

Father: _____ Paternal Grandfather: _____
Mother: _____ Paternal Grandmother: _____
Brothers: _____ Maternal Grandfather: _____
Sisters: _____ Maternal Grandmother: _____

Any family history of: Cancer _____ Heart Disease _____ Diabetes _____
High Blood Pressure _____ Bleeding disorders _____ Kidney Stones _____
Congenital Abnormalities _____ Prostate Problems _____

Patient Name: _____

NEW PATIENT PACKET

Please mark YES if the patient has had any of these problems.

GENERAL

FEVER..... YES
 WEIGHT LOSS..... YES
 LOSS OF ENERGY..... YES
 DIFFICULTY SLEEPING..... YES
 PROBLEMS WITH.....
 ANESTHESIA..... YES

NEURO

BLURRED/DOUBLE..... YES
 TEMPORARY BLINDNESS..... YES
 WEAKNESS IN EXTREMITIES..... YES
 TINGLING IN EXTREMITIES..... YES
 NUMBNESS IN EXTREMITIES..... YES
 SEIZURES..... YES
 VERTIGO (DIZZINESS)..... YES

ENDOCRINE

TEMPATURE TOLERANCE..... YES
 EXCESSIVE THIRST..... YES
 THYROID PROBLEMS..... YES
 STERIOD PROBLEMS..... YES
 SKIN/HAIR CHANGES..... YES

ABDOMEN

FOOD TOLERANCE..... YES
 INDIGESTION/HEARTBURN..... YES
 VOMITTING BLOOD..... YES
 JAUNDICE (YELLOW SKIN/EYES).... YES
 DIARRHEA..... YES
 CONSTIPATION..... YES
 CHANGE IN BOWEL HABITS..... YES
 BLOOD IN STOOLS..... YES
 ULCERS..... YES
 BLACK OR TARRY STOOLS..... YES

HEAD AND NECK

DIFFICULTY SWALLOWING... YES
 SORES IN MOUTH OR THROAT YES
 LUMPS IN NECK..... YES
 COLD OR EAR INFECTIONS... YES

GENITOURINARY**

KIDNEY OR BLADDER STONES..... YES
 KIDNEY/BLADDER INFECTIONS.. YES

HEAMTOLOGIC

EASY BRUISING..... YES
 BLEEDING TENDENCY..... YES

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information (PHI)

Your protected health information will be used by Urology Specialists of Nevada or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

This acknowledges your receipt and reading of USON's: Notice of Privacy Practices. You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You should review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

USON may or may not agree to restrict the use or disclosure of your protected health information.

If USON agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

USON reserves the right to modify the privacy practices outlined in this notice.

Signature

I have reviewed this consent form and give my permission to USON to use and disclose my health information in accordance with it.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS OR SELECTED PERSONAL CAREGIVERS

INFORMATION to Be Used or Disclosed

The information covered by this authorization includes:

All medical records and billing information and Protected Health Information

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Urology Specialists of Nevada

Persons to Whom Information May be Disclosed

Information described above may be disclosed to:

Authorization to disclose Protected Health Information to selected family members:

1.	_____	_____	_____
	Name	Date	Initials
2.	_____	_____	_____
	Name	Date	Initials
3.	_____	_____	_____
	Name	Date	Initials
4.	_____	_____	_____
	Name	Date	Initials
5.	_____	_____	_____
	Name	Date	Initials
6.	_____	_____	_____
	Name	Date	Initials

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Urology Specialists of Nevada. You should contact the Privacy Official to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of Patient (Print or Type)

Signature of Patient Date

Signature of Patient Representative Relationship of Patient Representative to Patient