

DOCTOR \_\_\_\_\_ DATE \_\_\_\_\_

ACCOUNT # \_\_\_\_\_

**PATIENT INFORMATION**

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_  
 Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone# ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Gender  Male  Female Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Marital Status  Single  Divorced  Married  Widowed  Separated Employer \_\_\_\_\_ Employer's Phone # \_\_\_\_\_

**RESPONSIBLE PARTY**

IF PATIENT IS NOT RESPONSIBLE FOR THE BILL, PLEASE INDICATE WHO IS RESPONSIBLE

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_  
 Responsible Party Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone # ( ) \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

**PATIENT CONTACT INFORMATION**

Urology Centers of Alabama, PC and its staff has my permission to discuss my account or medical conditions which may include symptoms, treatments, tests, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account.

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand authorizing the release of this information is voluntary and does not affect my access to treatment. I can refuse to make this authorization. I understand this authorization will remain in effect until I revoke it by completing a new form. I understand if this information is shared with these individuals above, that they may disclose my protected health information to other individuals. I have indicated my agreement with this authorization by signing below.

**REFERRAL INFORMATION**

Referred by \_\_\_\_\_ Phone Number \_\_\_\_\_  
 This is my Doctor  or a Relative  or a Friend

**INSURANCE INFORMATION**

Name of Insurance Company \_\_\_\_\_ Group Policy # \_\_\_\_\_ ID # \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 Relationship to Insured  Self  Child  Spouse  Other Birthdate \_\_\_\_\_ Gender  Male  Female  
 Phone # ( ) \_\_\_\_\_  
 Employer \_\_\_\_\_ Insured Social Security # \_\_\_\_\_ Effective Date of Insurance \_\_\_\_\_  
 Does Your Insurance Require A Referral? Yes  No  Do You Have A Waiting Period? Yes  No  How Much is Your Co-Pay? \_\_\_\_\_  
 Blue Cross of Alabama Contract # \_\_\_\_\_ Is This PMD: Yes  No   
 Medicare Contract # \_\_\_\_\_ Do You Have Part B? Yes  No   
 Medicaid Contract # \_\_\_\_\_  
 Other Insurance:  
 Name \_\_\_\_\_ Contract # \_\_\_\_\_ Group # \_\_\_\_\_  
 Employer \_\_\_\_\_ Insured Social Security # \_\_\_\_\_ Effective Date of Insurance \_\_\_\_\_

**Which Insurance is Primary?** \_\_\_\_\_

I accept full responsibility for all charges for services rendered by Urology Centers of Alabama, PC. I agree to pay all costs of collection, including reasonable attorney fees. I authorize the release of any medical information necessary for the completion of Insurance claim forms. I assign all benefits under my current health insurance policies and authorize payment directly to Urology Centers of Alabama, PC of any medical or government benefits due from my insurance and/or government program. I understand my insurance may not pay all of my charges and I agree to promptly pay the difference or the entire bill. I have received a copy of the Notice of Privacy Practices statement. I have authorized Urology Centers of Alabama, PC to discuss my protected health information with the above named individuals. I have read all of the information on the reverse side of this form and I agree to these policies.

Patient's or Authorized Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Fill out Both sides of this form completely

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

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Your Primary Care Physician or the Physician that Referred you \_\_\_\_\_

**List all Medicine you take including any Supplements or Over the Counter Drugs**

Name of Drug	Dosage - If Known	How Often

Please list any Drug or Food Allergies \_\_\_\_\_

**Your Medical History - Please Mark if you have or ever have had any of the following diseases**

- |                      |                                |                        |
|----------------------|--------------------------------|------------------------|
| Cancer _____         | Heart Attack _____             | Spastic Colon _____    |
| Type of Cancer _____ | Heart Failure _____            | Stroke _____           |
| Chest Pain _____     | High Blood Pressure _____      | Thyroid Problems _____ |
| Diabetes _____       | Irregular Heartbeat _____      | Ulcer _____            |
| Endometriosis _____  | Kidney Stones _____            |                        |
|                      | Lung Disease / Emphysema _____ |                        |
|                      | Mitral Valve Prolapse _____    |                        |

**Your Surgical History - Please Mark if you have had any of the following surgeries**

- |                    |                     |                    |                     |
|--------------------|---------------------|--------------------|---------------------|
| Angioplasty _____  | Heart By Pass _____ | Kidney _____       | Prostate _____      |
| Back Surgery _____ | Heart Valve _____   | Kidney Stone _____ | Stomach Ulcer _____ |
| Bladder _____      | Hernia _____        | Ovary _____        | Tonsils _____       |
| Gallbladder _____  | Hysterectomy _____  | Pacemaker _____    |                     |

Other Surgery - Please Specify \_\_\_\_\_

**Your Family Medical History - Please Mark if your Mother, Father, Brother or Sister have ever had any of the following**

- |                           |                                |
|---------------------------|--------------------------------|
| Bladder Cancer _____      | Kidney Cancer _____            |
| Diabetes _____            | Kidney Disease / Failure _____ |
| Heart Disease _____       | Prostate Cancer _____          |
| High Blood Pressure _____ |                                |

**Your Social History**

- Married ? Yes \_\_\_\_\_ No \_\_\_\_\_ OCCUPATION \_\_\_\_\_
- Smoke ? Yes \_\_\_\_\_ No \_\_\_\_\_ \_\_\_\_\_ packs per day for \_\_\_\_\_ years
- Drink Alcohol ? Yes \_\_\_\_\_ No \_\_\_\_\_ Occasional \_\_\_\_\_ or Regular \_\_\_\_\_
- Drinks Per Day \_\_\_\_\_

Do you have the following symptoms or diseases?

Fever	Yes	___	No	___	Blood in Urine	Yes	___	No	___
Weight Loss	Yes	___	No	___	Leakage of Urine	Yes	___	No	___
Weight Gain	Yes	___	No	___	Sexual Problems	Yes	___	No	___
Lethargy	Yes	___	No	___	Difficulty Urinating	Yes	___	No	___
Night Sweats	Yes	___	No	___	Frequent Urination	Yes	___	No	___
					Painful Urination	Yes	___	No	___
Double Vision	Yes	___	No	___	Currently Pregnant (Female)	Yes	___	No	___
Intermittent Loss of Vision	Yes	___	No	___	Abnormal Menstrual Periods (Female)	Yes	___	No	___
Glasses	Yes	___	No	___	Flank Pain	Yes	___	No	___
Cataracts	Yes	___	No	___					
					Muscle Weakness	Yes	___	No	___
Hearing Loss	Yes	___	No	___	Joint Pain	Yes	___	No	___
Ringing in Ears	Yes	___	No	___					
Sinus Infections	Yes	___	No	___	Rash	Yes	___	No	___
Sleep Apnea	Yes	___	No	___	Skin Lesions	Yes	___	No	___
Nose Bleeds	Yes	___	No	___	Bruises Easily	Yes	___	No	___
Trouble Swallowing	Yes	___	No	___					
					Memory Loss	Yes	___	No	___
Chest Pain at Rest	Yes	___	No	___	Headaches	Yes	___	No	___
Chest Pain with Exertion	Yes	___	No	___	Mini Strokes	Yes	___	No	___
Irregular Heartbeat	Yes	___	No	___	Tremor	Yes	___	No	___
Palpitations	Yes	___	No	___	Blackout	Yes	___	No	___
Swollen Ankles	Yes	___	No	___	Alzheimers	Yes	___	No	___
Leg Cramps with Exercise	Yes	___	No	___					
Fainting	Yes	___	No	___	Depression	Yes	___	No	___
					Schizophrenia	Yes	___	No	___
Shortness of Breath with Exertion	Yes	___	No	___	BiPolar Disorder	Yes	___	No	___
Shortness of Breath at Rest	Yes	___	No	___	Anxiety Disorder	Yes	___	No	___
Chronic Cough	Yes	___	No	___					
Asthma	Yes	___	No	___	Hot Flashes	Yes	___	No	___
Trouble Breathing when Lying down	Yes	___	No	___	Post Menopausal	Yes	___	No	___
					Thyroid Problems	Yes	___	No	___
Heartburn or Indigestion	Yes	___	No	___					
Nausea or Vomiting	Yes	___	No	___	Anemia	Yes	___	No	___
Blood in Stool	Yes	___	No	___	Trouble with Blood Clotting	Yes	___	No	___
Constipation	Yes	___	No	___	Sickle Cell Disease or Trait	Yes	___	No	___
Diarrhea	Yes	___	No	___	Previous Transfusions	Yes	___	No	___
Acid Reflux	Yes	___	No	___	Abnormal Bleeding	Yes	___	No	___
					Immune Deficiency	Yes	___	No	___
					HIV	Yes	___	No	___
					Lupus	Yes	___	No	___
					Hepatitis C	Yes	___	No	___