AUI
ADVANCED UROLOGY INSTITUTE

# ADVANCED UROLOGY INSTITUTE
# PATIENT INFORMATION FORM

TODAY'S DATE_____

NAME_____ HOME PHONE_____ CELL/OTHER PHONE_____

Primary Address_____ CITY_____ STATE/ZIP_____

Secondary Address_____ CITY_____ STATE/ZIP_____
(If Applicable)

Dates residing at SECONDARY ADDRESS_____ PHONE _____

DATE OF BIRTH_____ SOCIAL SECURITY #_____ MALE_____ FEMALE_____

MARITAL STATUS_____ SPOUSE/NEAREST RELATIVE_____ CONTACT #_____

EMERGENCY CONTACT OTHER THAN SPOUSE/RELATIVE_____ CONTACT #_____

YOUR RACE: Please check one: ☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ OTHER_____

YOUR ETHNICITY: Please check one: ☐ HISPANIC /LATINO ☐ NON-HISPANIC/NON LATINO ☐ OTHER_____

YOUR PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ RUSSIAN ☐ OTHER _____

YOUR EMAIL ADDRESS: _____ Preferred Method of Contact: _____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ DISABLED ☐ RETIRED ☐ STUDENT ☐ UNEMPLOYED ☐ OTHER_____

EMPLOYER_____ WORK TELEPHONE NUMBER_____

How do you plan to pay for your medical treatment with us? ☐ Self pay (Cash/Check/Visa/MC) ☐ Medicare ☐ Medicare Supplement
☐ Medicare HMO ☐ Private Insurance (HMO, PPO, Indemnity) ☐ Worker's Compensation

PRIMARY INSURANCE _____ SECONDARY INSURANCE_____

POLICY NUMBER_____ POLICY NUMBER_____

GROUP NUMBER_____ GROUP NUMBER_____

Policyholder Name_____ Policyholder Name_____

Policyholder DOB & SS#_____ Policyholder DOB & SS#_____

Relationship to Policyholder_____ Relationship to Policyholder_____

**PLEASE READ AND SIGN:**

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I AGREE TO PAY ALL AMOUNTS NOT PAID BY MY INSURANCE CARRIER ACCORDING TO MY POLICY PROVISIONS AND THE PROVIDER CONTRACT. IN THE EVENT OF A DISPUTED PAYMENT, IT IS MY RESPONSIBILITY TO PAY FOR THE CHARGES AND DISPUTE THE PAYMENT WITH MY INSURANCE CARRIER. IT IS ALSO MY RESPONSIBILITY TO RECEIVE AUTHORIZATION/REFERRALS FOR ANY OFFICE VISIT TO ADVANCED UROLOGY INSTITUTE.

I HEREBY AUTHORIZE MY PHYSICIAN TO ACCESS MY PRESCRIPTION HISTORY IN ORDER TO DETERMINE THE CORRECT FORMULARY IN ACCORDANCE WITH MY HEALTH INSURANCE BENEFITS.

Primary care physician's name and phone number: _____

Pharmacy name and phone number_____

PATIENT/GUARDIAN SIGNATURE _____ HOW DID YOU HEAR ABOUT US? _____

ADVANCED UROLOGY INSTITUTE

# ADVANCED UROLOGY INSTITUTE
# ANNUAL VISIT -- PATIENT HISTORY FORM

NAME_____ TODAY'S DAY_____ DATE OF BIRTH_____

NAME OF YOUR PRIMARY CARE DOCTOR_____

CHIEF COMPLAINT/REASON OF VISIT_____

PHARMACY NAME AND LOCATION_____

ALLERGIES TO ANY MEDICATIONS, FOODS OR IV CONTRAST/X-RAY DYE_____

PLEASE COMPLETE YOUR MOST CURRENT MEDICATION LIST:

| Name of Medication/Over the Counter meds/Vitamins/Herbal Meds | Strength | # of times taken per day |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| 11. | | |
| 12. | | |

PAST MEDICAL HISTORY

PLEASE LIST ANY NEW MEDICAL PROBLEMS OR SURGERIES YOU HAVE HAD IN THE PAST YEAR (OR SINCE YOUR LAST VISIT)

_____

_____

_____

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ANNUAL VISIT – PATIENT HISTORY FORM

NAME_____ TODAY'S DAY_____DATE OF BIRTH_____

SOCIAL HISTORY:
Do you smoke cigarettes? _____NO _____YES How many packs per day?_____

If NO, have you ever smoked? _____NO _____YES – When did you quit? _____

Do you drink alcohol? _____Never _____Occasional _____Daily – # of Drinks per day _____

ARE YOU: _____MARRIED _____DIVORCED _____SINGLE (NEVER MARRIED) _____WIDOWED

REVIEW OF SYSTEMS: Please check YES or NO

General/Constitutional
- Headache ( )Yes ( )No
- Chills ( )Yes ( )No
- Fever ( )Yes ( )No

Opthamologic
- Blurring of Vision ( )Yes ( )No
- Double Vision ( )Yes ( )No
- Eye Pain ( )Yes ( )No
- Glaucoma ( )Yes ( )No

HEENT/Neck
- Ear Infection ( )Yes ( )No
- Sinus Problems ( )Yes ( )No
- Sore Throat ( )Yes ( )No

Endocrine
- Excessive thirst ( )Yes ( )No
- Too hot/too cold ( )Yes ( )No
- Fatigue ( )Yes ( )No

Respiratory
- Cough ( )Yes ( )No
- Shortness of breath ( )Yes ( )No
- Wheezing ( )Yes ( )No

Cardiovascular
- Chest Pain ( )Yes ( )No
- High Blood Pressure ( )Yes ( )No
- Varicose Veins ( )Yes ( )No

Urologic
- Urinary Retention ( )Yes ( )No
- Painful Urination ( )Yes ( )No
- Urinary Frequency ( )Yes ( )No

Neurologic
- Dizziness ( )Yes ( )No
- Numbness/Tingling ( )Yes ( )No
- Tremor ( )Yes ( )No

Musculoskeletal
- Neck Pain ( )Yes ( )No
- Back Pain ( )Yes ( )No
- Joint Pain ( )Yes ( )No

Dermatologic
- Boils ( )Yes ( )No
- Itching ( )Yes ( )No
- Rash ( )Yes ( )No

Hematology
- Swollen Glands ( )Yes ( )No
- Blood Clotting problem ( )Yes ( )No

Psychiatric
- Insomnia ( )Yes ( )No
- Anxiety ( )Yes ( )No
- Depression ( )Yes ( )No

Gastrointestinal
- Abdominal Pain ( )Yes ( )No
- Heartburn/Indigestion ( )Yes ( )No
- Nausea/Vomiting ( )Yes ( )No

COMMENTS:_____


# NOTICE OF PRIVACY PATIENT ACKNOWLEDGEMENT

Patient Name _____ Date of Birth _____

I understand that, under The Health Insurance Portability Accountability of 1996 and HIPAA Omnibus Final Rule of 2013, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understand The Notice of Privacy Practices. I agree that my signature will be valid as long as I am a patient of Advanced Urology Institute.

The practice reserves the right to change the terms of its Notice of Privacy Practices. I understand the practice will provide current Notice of Privacy Practice on request.

I authorize AUI to release to release my PHI to the following individuals or service provides:

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Patient Signature _____ Date _____

I was unable to obtain the patient's signature:

Name _____ Date _____