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***Patient Information***

*(****Información para el paciente)***

Date (Fecha): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (nombre del paciencte): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address (Dirección de envio): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City (ciudad): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State (Estado): \_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip (Código postal): \_\_\_\_\_\_\_\_

Circle One (Uno del círculo): Male Female

Social Security# (Seguridad social): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date (Fecha de nacimiento): \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_Age (edad): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Phone (número de teléfono:(\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cellphone (número de teléfono celular) :(\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:

Secondary Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Marital Status (estado civil): \_\_\_\_\_\_\_\_\_Spouse's Name (Nombre de Spouse): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (Contacto de emergencia): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party Information (Información partido responsible):**

Primary Insurance: Policy Number: Group #:

Name (nombre): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (número de teléfono) :(\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Dirección): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City(ciudad): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State (Estado): \_\_\_\_\_\_Zip (Código postal): \_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Person SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Secondary Insurance: Policy Number: Group #:

Name (nombre): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (número de teléfono) :(\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Dirección): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City(ciudad): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State (Estado): \_\_\_\_\_\_Zip (Código postal): \_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Person SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

**Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedure, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, and other balance not paid for by your insurance company. (**Por favor, recuerde que el seguro se considera un método de reembolsar al paciente por honorarios al médico y no es un sustituto para el pago. Algunas empresas pagan una cantidad fija por cierto procedimiento, y otros pagan un porcentaje de la carga. Es su responsabilidad pagar cualquier monto deducible, coseguro y otros saldo no pagado por su compañía de seguros.

**If payment is not made in full, I agree to pay all costs of collection, including attorney fees. I authorize Advanced Urology Institute to furnish information to all insurance carriers concerning my illness and treatment and I hereby assign to Advanced Urology Institute all payment for medical services rendered to me (the patient) or my dependents, in the event an insurance claim is filed by the practice. I further agree that a photocopy of this agreement shall be as valid as the original. (**Si el pago no se realiza en su totalidad, estoy de acuerdo en pagar todos los costos de colección, incluyendo honorarios de abogado. Autorizo a Urología facilitar información a todas las compañías aseguradoras sobre mi enfermedad y tratamiento y por la presente asignar Urología todos los pagos por servicios médicos prestados a mí (el paciente) o mis dependientes, en el caso de una reclamación de seguro es presentada por la práctica. Estoy más de acuerdo que una copia de este acuerdo será tan válida como la original.)

Patient's Signature (Firma de Patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (fetcha): \_\_\_\_\_\_\_\_\_\_\_\_

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***Policy for Notification of Test Results (*Política de notificación de resultados de la prueba)**

Due to the federal guidelines, Advanced Urology Institute has implemented a policy for notifying our patients about their test results. (Debido a las directrices federales, la práctica de la urología ha implementado una política para notificar a nuestros pacientes acerca de sus resultados.)

Call: Home Phone# (teléfono de casa) (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cell Phone# (teléfono celular) (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the following which apply (Compruebe los siguientes puntos que se aplican):**

 I approve you to leave a message on the answering machine or voice mail.

 (Apruebo que deja un mensaje en el contestador o buzón de voz.)

 I approve you to leave a message with the person answering the phone.

 (Apruebo que deje un mensaje con la persona que contesta el teléfono.)

This authorization will be valid until we receive further notification from you. (Esta autorización será válida hasta que recibir más notificaciones de usted.)

Patient's Signature (Firma de Patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date (fetcha): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***PATIENT MEDICAL INFORMATION SHEET***

NAME(nombre):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB(Fecha de nacimiento):\_\_\_\_\_\_\_\_\_\_\_\_ DATE(fecha):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION ALLERGIES (MEDICAMENTOS ALERGIAS): (Circle/Fill all that apply)**

|  |  |  |  |
| --- | --- | --- | --- |
| Bactrim | Codeine | Penicillin | Sulfa |
| Cipro/Levaquin | Nitrofurantoin | Hydrocodone | Tetracycline |
| Statins | Latex | IV Dye/Iodine | NO ALLERGIES |
|  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SOCIAL HISTORY (Historia Social):**

Recreational Drug Use (Uso de drogas recreativas):Current / Past / Never

Smoking(fumar): Currently Past Never Packs/day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quit:\_\_\_\_\_\_\_\_\_\_

Alcohol: Currently Past Never Drinks/day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quit:\_\_\_\_\_\_\_\_\_\_

**List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don’t know, please call your pharmacist to confirm.** (Lista todos los medicamentos usted toma, incluyendo vitaminas y medicamentos de venta libre (OTC). Incluyen dosis específicas y cuando se toma. Si no sabes, por favor llame a su farmacéutico para confirmar.)

**Medications** **OTC and vitamins**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PERSONAL MEDICAL HISTORY: (Please circle all that apply)** (Antecedentespersonales: Por favor circule las que apliquen)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ADHD | COPD | HIV | Peptic Ulcer |  |
| Alcoholism | Dementia | Hepatitis | Psoriasis |  |
| Allergies | Depression | Hypertension | Pulmonary |  |
| Anemia | Diabetes: 1or 2  | Kidney Stones | Prostate Cancer  |  |
| Arthritis | Diverticulitis | Kidney Disease | Rheumatoid |  |
| Arrhythmia | DVT (Blood Clot) | Kidney Cancer | Sciatica |  |
| Anxiety | Eczema | Lung Cancer | Seizure Disorder |  |
| Apnea | Emphysema | Lupus | Sleep Disorder |  |
| Asthma | Gallstones | Liver Disease | Stroke |  |
| Bipolar Disorder | GERD | Macular Degeneration | Thyroid Disorder |  |
| Bladder Cancer | Glaucoma | Migraines | Ulcerative Colitis |  |
| Bleeding Disorder | High Cholesterol | Nosebleeds | Urinary Incontinence |  |

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History: Please list all prior surgeries and approximate dates performed.**

(Historia quirúrgica: Enumere todas las cirugías previas y fechas aproximadas realizadas.)

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**FAMILY HISTORY** (HISTORIA DE LA FAMILIA):

**FATHER** (padre): Living(viven): Age\_\_\_\_\_\_\_\_ Deceased(muertos): Age\_\_\_\_\_\_\_\_

COPD/Emphysema Colon Cancer Stroke Heart Disease

Breast Cancer Bladder Cancer Kidney Disease Prostate Cancer

High Blood Pressure Diabetes 1 or 2

Other (otros): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MOTHER** (madre): Living(viven): Age\_\_\_\_\_\_\_\_\_ Deceased(muertos): Age: \_\_\_\_\_\_\_\_\_\_

COPD/Emphysema Colon Cancer Stroke Heart Disease

Breast Cancer Bladder Cancer Kidney Disease High Blood Pressure

Diabetes 1or2

Other (otros): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Siblings**(hermanos)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

List other medical providers you see on a regular basis (i.e. Cardiologist, Medical Health Provider, Pulmonologist, etc.) (Lista de otros proveedores de servicios médicos que ver sobre una base regular)

**Primary Care Physician** (médico de atención primaria)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cardiologist** (cardiólogo)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pumonologist** (pumonologist)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other** (otros)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy** (farmacia preferida):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number (**número de teléfono)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient signature (firma del paciente): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date (fecha): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_