ROGUE VALLEY UROLOGY P.C.

E-Mail ____________________

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE NAME | HOME TELEPHONE ( )

MAILING ADDRESS | CITY | STATE | ZIP

BIRTHDATE / / | SEX ☐M ☐F | SOCIAL SECURITY # | PREFERRED PHARMACY

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER | REFERRING PROVIDER | PRIMARY CARE PROVIDER

DRIVERS LICENSE # | STATE | EMERGENCY CONTACT | RELATIONSHIP | TELEPHONE # ( )

RACE: ASIAN ☐ HISPANIC ☐ CAUCASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR NATIVE AMERICAN ☐ NATIVE AMERICAN ☐

PRIMARY LANGUAGE | ETHNICITY: HISPANIC OR LATINO ☐ NON-HISPANIC OR LATINO ☐ OTHER OR UNDETERMINED ☐

EMPLOYER | JOB TITLE | WORK TELEPHONE ( )

EMPLOYER ADDRESS | CITY | STATE | ZIP

MAY WE CALL TO CONFIRM YOUR APPOINTMENT (HOME ☐YES ☐NO) (WORK ☐YES ☐NO) | CELL # ( )

IF MINOR: RESPONSIBLE PARTY ☐ PARENT ☐ OTHER (CHECK ONE)

LAST NAME | FIRST NAME | MIDDLE NAME | HOME TELEPHONE ( )

ADDRESS | CITY | STATE | ZIP

RELATIONSHIP TO PATIENT | BIRTHDATE | SOCIAL SECURITY # | DRIVERS LICENSE # | STATE

EMPLOYER | EMPLOYER ADDRESS | WORK TELEPHONE ( )

PRIMARY INSURANCE INFORMATION

RELATIONSHIP OF PATIENT TO POLICYHOLDER

☐SPOUSE ☐CHILD ☐SELF ☐OTHER

POLICYHOLDER NAME | DOB / / | POLICYHOLDER EMPLOYER

INSURANCE COMPANY NAME | TELEPHONE #

IDENTIFICATION NUMBER | GROUP NUMBER

SECONDARY INSURANCE INFORMATION

RELATIONSHIP OF PATIENT TO POLICYHOLDER

☐SPOUSE ☐CHILD ☐SELF ☐OTHER

POLICYHOLDER NAME | DOB / / | POLICYHOLDER EMPLOYER

INSURANCE COMPANY NAME | TELEPHONE #

IDENTIFICATION NUMBER | GROUP NUMBER

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Rogue Valley Urology, P.C. all of the insurance benefits due me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original.

PATIENT OR GUARANTOR SIGNATURE ____________________ DATE ____________________

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Rogue Valley Urology to use and disclose the health and medical information of

____DOB:_____________

or the purpose of **Treatment, Payment, and Health Care Operations.**

Treatment (includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

Health Care Operations (includes the necessary administrative and business functions of our office.

Prior to signing this CONSENT you may review Rogue Valley Urology's entire "Notice of Privacy Practices" for additional information about the uses and disclosures of information as described in the summary and this consent. Please verify that you have received a copy of our Notice by placing your initials here:______.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. The entire Notice will be posted in our lobby indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

May we have permission to check a medication history on you? Yes or No

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Rogue Valley Urology has already used or disclosed the information in reliance on this CONSENT.

Date:_______________ ____________________________________
(Signature of Patient)

or

Date:_______________ ____________________________________
(Signature of Person authorized by law)

ROGUE VALLEY UROLOGY P.C.

At Providence Plaza

HEALTH HISTORY

Name: ____________________

Birthdate: ____________ Age: ________

Phone (H) ____________ (W) ________

Primary Doctor: ____________________

Date ____________________ Referring Physician ____________

Occupation **(past and present)** ____________________

Reason for coming ____________________

Marital Status ________ Emergency Contact ____________ Phone # ________

PAST MEDICAL HISTORY: Have you had any of the following problems?

Medical Illnesses

- ☐ Lung disease
- ☐ Asthma or Emphysema
- ☐ Tuberculosis or abnormal skin test
- ☐ Heart disease - Heart attack
- ☐ High blood pressure
- ☐ Cholesterol problem
- ☐ Ulcers
- ☐ Liver disease or hepatitis
- ☐ Acid reflux or hiatal hernia
- ☐ Sexually transmitted disease
- ☐ Brain or nerve disease (stroke)
- ☐ Migraine
- ☐ Depression/Anxiety
- ☐ Seizures
- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Anemia
- ☐ Blood clots or phlebitis
- ☐ Cancer ________

PAST UROLOGIC HISTORY

____

Operations/Hospitalization (include tonsillectomy and appendectomy)

Date	Operation/Hospitalization	Complications

Severe Accidents and Injuries and date

____

MEDICATIONS CURRENTLY TAKEN regularly or occasionally. Include vitamins, birth control pills, sleeping pills, pain pills, laxatives, aspirin - with dosage. Please bring these with you if you are are unsure.

____

ALLERGIES and Adverse Medication Reactions (please list reaction)

____

Recreational drugs? ☐ No ☐ Yes **IV drug user?** ☐ No ☐ Yes **Last HIV test?** ________

Tobacco Use? ☐ No ☐ Yes Pkgs/day ________ # of years ________ Quit? ________ Year quit ______

Alcohol Use? ☐ No ☐ Yes Drinks/day ________ Drinks/week ________ ☐ Beer ☐ Wine ☐ Hard Liquor

Female Patients

Last menstrual period ________ Last pap smear ________

Number of pregnancies ________ Number of births ________

SEE REVERSE SIDE

FAMILY HISTORY

General health; major health problems & illnesses, OR age and cause of death

	Age of death	Age if alive	Prostate Cancer	Breast Cancer	Kidney / Stones	Other
Mother						
Father						
Brothers						
Sisters						

Significant illness in Grandparents, Cousins, Aunts, Uncles or Children?

____

____

REVIEW OF SYSTEMS: Do you have, or have you had *in the past month,* any of the following? (Place a check mark next to those you have experienced).

YES	NO	**General**
☐	☐	Recent fever
☐	☐	Weight Loss
☐	☐	Night Sweats
☐	☐	Fatigue
☐	☐	Change in lymph nodes
☐	☐	Chills
		Eyes
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Vision Loss
		Ears/Nose/Throat/Neck
☐	☐	Tinnitus
☐	☐	Decreased Hearing
☐	☐	Nosebleeds
☐	☐	Loose teeth
☐	☐	Sore Throat
☐	☐	Goiter
☐	☐	Difficulty swallowing
		Cardiovascular
☐	☐	Chest pain
☐	☐	Heart Attack
☐	☐	Irregular beats
☐	☐	Murmur
☐	☐	Leg swelling
☐	☐	Clots in legs

YES	NO	**Pulmonary/Respiratory**
☐	☐	Shortness of breath
☐	☐	Wheezing
☐	☐	Cough (productive)
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Tuberculosis
		Digestive/G.I.
☐	☐	Severe Heartburn
☐	☐	Vomiting
☐	☐	Ulcers
☐	☐	Abdominal pain
☐	☐	Jaundice/Hepatitis
☐	☐	Bloody bowel movements
		Genitourinary
☐	☐	Burning on urination
☐	☐	Bloody urine
☐	☐	Incontinence
☐	☐	Infections
☐	☐	Difficulty urination
☐	☐	Urination at night: # times
☐	☐	Difficulty with erections
☐	☐	Sexually transmitted diseases
☐	☐	Multiple sexual partners
		Skeletal
☐	☐	Fractures
☐	☐	Arthritis

YES	NO	**Skin/Breasts**
☐	☐	Rashes
☐	☐	Changes in mole
☐	☐	Discharge from nipples
☐	☐	Lumps
		Neurologic/Psychiatric
☐	☐	Convulsions
☐	☐	Stroke
☐	☐	Headaches
☐	☐	Depression, low motivation
☐	☐	Numbness/Change in vision
☐	☐	Anxiety, excessive worry
		Blood/Lymphatic
☐	☐	Easy Bruising
☐	☐	Excessive bleeding
☐	☐	Transfusions

Do you have an Advanced Directive for end-of-life? ____________

UPDATED/SIGNATURE