



PATIENT INFORMATION

Last			First			Middle			Marital Status			SEX		
									S M W D			M F		
Name of Spouse (or Parent if patient is a minor)									Preferred Language			Ethnicity		
												<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		
Patient's Street Address									Race					
									<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other					
City			State			Zip Code			Emergency Contact					
									Name _____					
									Phone _____					
Social Security #			Birthdate						Relationship _____					
									Physician Names/Numbers:					
Home Phone			Cell Phone						Primary _____					
									Referring _____					
									Other _____					
Employer			Work Phone			Email Address								

INSURANCE INFORMATION	Group# & Employer	Policy Certificate or I.D. #	POLICY HOLDER NAME & DOB
PRIMARY			
SECONDARY			

AUTHORIZATION

I hereby authorize St. Louis Urological Surgeons to furnish information to insurance carriers concerning this illness/accident and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance or workers compensation. I hereby authorize photocopies of this authorization form to be valid as the original. I consent to disclosure of my medical information to outside agencies for the purpose of providing healthcare services to me. If I fail to obtain a referral, I understand that I am financially responsible. I acknowledge that I have received the mandatory information regarding "Notice of Privacy Practices." (HIPAA)

X SIGNATURE _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION (Your Signature is Required)

Do You Authorize Another Person To Receive Your Medical Information? Yes No
 If YES, Who _____ Relationship to Patient _____
 Do You Authorize Another Person To Receive Your Billing Information? Yes No
 If YES, Who _____ Relationship to Patient _____

X SIGNATURE _____ DATE _____

PATIENT HISTORY

Date _____

Patient Name _____ DOB _____ Height _____ Weight _____

Reason for Visit _____

Date Symptoms Began _____

PAST MEDICAL HISTORY: (High Blood Pressure, Stroke, Diabetes, etc.)

PAST SURGICAL HISTORY:

Surgery/Hospitalization	Date	Surgery/Hospitalization	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREGNANCY HISTORY: (if applicable) Number of Pregnancies _____ Number of Births _____

FAMILY HISTORY:

	Yes	No	Family Member		Yes	No	Family Member
1. Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	5. Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	6. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____	7. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	8. Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY:

Occupation: _____ Marital Status: S M W D Spouse's Name: _____

Smoke? Yes No Quit When did you stop smoking? _____ If yes, how much? _____ # of pack/day _____ # of years _____

Alcohol? Yes No Quit If yes, how much? _____

Coffee - How much? _____ Tea - How much? _____ Soda - How much? _____

Have you ever used recreational drugs? (i.e. marijuana, cocaine) Yes No If yes, what and when _____

REVIEW OF SYSTEMS: Do you now or have you had any problems related to the following systems? Circle Yes or No

<p>Eyes</p> <p>Glaucoma Y N</p> <p>Cataracts Y N</p> <p>Glasses/Contacts Y N</p> <p>Other Y N</p>	<p>Endocrine</p> <p>Excessive thirst Y N</p> <p>Too hot/cold Y N</p> <p>Tired a lot Y N</p> <p>Other Y N</p>	<p>Respiratory</p> <p>Wheezing Y N</p> <p>Frequent cough Y N</p> <p>Shortness of breath Y N</p> <p>Other Y N</p>
<p>Constitutional Systems</p> <p>Weight Loss Y N</p> <p>Weight Gain Y N</p> <p>Chills Y N</p> <p>Fever Y N</p> <p>Night Sweats Y N</p> <p>Other Y N</p>	<p>Genitourinary</p> <p>Change in stream Y N</p> <p>Urinary frequency > 8x /day Y N</p> <p>Blood in urine Y N</p> <p>Flank or side pain Y N</p> <p>Burning or pain with urination Y N</p> <p>Other Y N</p>	<p>Gastrointestinal</p> <p>Abdominal pain Y N</p> <p>Nausea/vomiting Y N</p> <p>Indigestion/heartburn Y N</p> <p>Constipation Y N</p> <p>Diarrhea Y N</p>
<p>Cardiovascular</p> <p>Chest pain/pressure Y N</p> <p>Irregular heartbeat Y N</p> <p>Swelling in ankles Y N</p> <p>Other Y N</p>	<p>Musculoskeletal</p> <p>Muscle weakness Y N</p> <p>Joint pain (swelling) Y N</p> <p>Back pain Y N</p> <p>Other Y N</p>	<p>Sexual History</p> <p>Change in sex drive? Y N</p> <p>Sexual response satisfactory? Y N</p> <p>Other Y N</p>
<p>Hematological/Lymphatic</p> <p>Swollen glands Y N</p> <p>Blood clotting problem Y N</p> <p>Bruise easily Y N</p> <p>Other Y N</p>	<p>Neurological</p> <p>Tremors Y N</p> <p>Dizzy spells Y N</p> <p>Numbness/tingling Y N</p> <p>Paralysis Y N</p> <p>Other Y N</p>	<p>Psychiatric</p> <p>Do you feel depressed? Y N</p> <p>Do you feel anxious? Y N</p>

Please explain any Yes answer on the back of this form.



ST. LOUIS
UROLOGICAL
SURGEONS

TO: All Male Patients

FROM: St. Louis Urological Surgeons

SUBJECT: Insurance Payment Guidelines

As you prepare for your visit to the physician we must make you aware of a potential situation regarding insurance coverage for certain diagnoses and conditions which are commonly treated by urologists. Specifically, it is possible that treatment for erectile dysfunction, impotence, infertility, and related conditions may not be reimbursed by your insurance carrier. In this case, you will be responsible for payment for any treatment you receive related to these conditions.

While some insurance plans do cover such treatment, there is no way for us to know in advance whether your carrier will, in fact, cover you. You may wish to contact your carrier prior to your visit to determine what their policy is.

If you are a Medicare patient you should know that these diagnoses are generally covered, though you may have a secondary insurance which would not pay.

We ask you to sign the following statement so that there is no confusion regarding this issue:

"I understand that if I am ever treated for erectile dysfunction, impotence, infertility, or a related diagnosis, and that any of my insurance carriers refuse payment for this treatment, I am fully responsible for paying all charges incurred during the course of my treatment.

Signature

DOB

Date