GEORGIA UROLOGY, P.A.

It is our desire to make your first visit to our office smooth and efficient. To do this, we ask that you actively participate in your care and have outlined a few important requests.

• We no longer use paper charts; all information in your medical record is entered electronically. Therefore, we ask that you either:
  ❖ COMPLETE the NextMD forms sent to you via EMAIL and follow the instructions to transmit them to us
  ❖ OR
  ❖ Return your COMPLETED paperwork at least 2 to 3 days before your appointment.

This allows us to electronically create and review your medical record before your arrival.

• If you have been referred to our practice for an elevated PSA, please bring PSA TEST results with you to your appointment. This information is crucial to your care.

• Please bring X-RAY FILMS, CD IMAGE DISCS, AND ANY REPORTS about any radiology testing you may have had. We do not want to duplicate the same tests or delay your care.

• Our doctors specialize in urology, which deals with issues concerning the urinary bladder, kidneys, prostate, and other urinary concerns. The first step in detection of a urinary issue is testing of a urine specimen. PLEASE BE PREPARED TO LEAVE A SPECIMEN AT EACH APPOINTMENT.

Thank you for your cooperation. We look forward to meeting with you!
Date: ________________

Patient’s Full Name: ____________________________________________________________________

Last     First     Middle

Birthdate: ___/___/____ Age:______ Sex:_________

Address: ______________________________________________________________________________

Street     City     State     Zip Code

Home Phone: (_____)-_____-_____ Work Phone: (_____)-_____-______ Cell: (_____)-_____-______

Marital Status: ______________________________ Spouse’s Name: _____________________________

Person Responsible for Bill: _____________________________ Relationship to Patient: ______________

Address (if different from above): __________________________________________________________

Street     City     State     Zip Code

Primary Care Physician: _______________________________________ Phone: (____)-____-______

Referring Physician: ____________________________________________ Phone: (____)-____-______

Pharmacy: ____________________________________________________ Phone: (____)-____-______

Patient’s Employer: _____________________________________________________________________

Employer’s Address: ____________________________________________________________________

Street     City     State     Zip Code

Emergency Contact: ______________________________________________ Phone: (____)-____-______

Address: ______________________________________________________________________________

Street     City     State     Zip Code

Primary Insurance Company: ______________________________________________________________

ID Number: ____________________ Group Number: _______________ Specialist Co-Pay: _____________

Subscriber’s Name: ____________________________________________ Birthdate: ___/___/____

Relationship to Patient: ________________________________

Subscriber’s Employer: _________________________________________ Phone: (____)-____-______

Employer’s Address: ____________________________________________________________________

Street     City     State     Zip Code

Secondary Insurance Company: ______________________________________________________________

ID Number: ____________________ Group Number: _______________ Specialist Co-Pay: _____________

Subscriber’s Name: ____________________________________________ Birthdate: ___/___/____

Relationship to Patient: ________________________________

Subscriber’s Employer: _________________________________________ Phone: (____)-____-______

Employer’s Address: ____________________________________________________________________

Street     City     State     Zip Code

Payment is REQUIRED at the time of service and is the responsibility of the patient. Services WILL NOT be rendered to patients without valid referrals.

I authorize Georgia Urology to perform routine medical evaluations and diagnostic procedures to assist in the diagnosis and treatment of my health problem. I also authorize Georgia Urology to release pertinent medical information to my primary care physician. Georgia Urology will abide by all HIPAA regulations regarding privacy and confidentiality.

Patient’s Signature: _____________________________________________ Date: ___/___/______
GEORGIA UROLOGY, P.A. – ACKNOWLEDGEMENT & AUTHORIZATION

PLEASE READ CAREFULLY: All charges or co-payments, if applicable, are due at the time of services. The patient is responsible for all fees, regardless of insurance coverage unless the services are for properly authorized workmen’s compensation or for services covered under a contractual agreement between this Medical Practice and your insurance carrier. I understand that I need to provide, where needed, referrals from my Primary Care Physician. Furthermore, I understand that I need to notify Georgia Urology, P.A. of tests or other treatments that may not be covered by my insurance policy. I realize that I am responsible for fees that are not covered by my insurance carrier. If hospitalization is indicated, the patient is responsible for ensuring Georgia Urology, P.A. is informed of the necessary pre-certification requirements.

ASSIGNMENT OF BENEFITS: I hereby assign payment of medical benefits, as may be payable to me, to Georgia Urology, P.A. for any benefits due to me for medical or surgical care, by reason of such treatment rendered to me or the patient/insured.

HIPAA COMPLIANCE NOTICE: I hereby acknowledge that I have read the GEORGIA UROLOGY, P.A. –NOTICE OF PRIVACY POLICIES that describes how information about me may be used and disclosed and how I may obtain access to this information. Furthermore, I acknowledge that I understand these policies and have received a personal copy of this information for my records. Copies are available at any of our offices. GEORGIA UROLOGY, P.A. will abide by all HIPAA regulations regarding privacy and confidentiality as outlined in our NOTICE OF PRIVACY POLICIES.

AUTHORIZATION TO RELEASE LAB AND DIAGNOSTIC TEST RESULTS: I understand that GEORGIA UROLOGY’s policy is to notify patients of any abnormal labs or diagnostic test results. We will notify you as soon as possible. I indicated below which results may be released and to whom that information may be released. (You may choose more than one option).

_________ Give my results to me personally. My daytime phone number is (____)-____-______. (If you are not available to speak to us, we will leave a message to call our office).

_________ If my results are benign (or within normal limits), you may leave my results on my answering machine at (check all that apply):

<table>
<thead>
<tr>
<th>Phone Type</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>(<strong><strong>)-</strong></strong>-_____</td>
</tr>
<tr>
<td>Work</td>
<td>(<strong><strong>)-</strong></strong>-_____</td>
</tr>
<tr>
<td>Cell</td>
<td>(<strong><strong>)-</strong></strong>-_____</td>
</tr>
</tbody>
</table>

_________ If you cannot reach me personally, I authorize Georgia Urology, P.A. to release my results to another person specifically:

Name: ______________________________________________________________________________

Relationship: __________________________________________________________________________

Daytime Phone Number: (____)-____-_____ 

AUTHORIZATION TO RELEASE INFORMATION: I authorize Georgia Urology, P.A. to release all information necessary to secure payment, transmit and process claims electronically or through any other reasonable and customary means, including, but not limited to Medicare.

CONSENT FOR TREATMENT: I voluntarily consent to my treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physician. I have read this consent, and I am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to me concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND VOLUNTARILY AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

_______________________________  ______________________________________  _____/_____/_______
Patient’s Name (PRINT)  Patient’s Signature  Date
GEORGIA UROLOGY, P.A.
ADMISSION HISTORY

Name ________________________________ Date of birth _________________________

Today's date __________________________

What is the name of the doctor who referred you to Georgia Urology? ________________________________

For your convenience, Georgia Urology P.A. may send prescriptions electronically to participating pharmacies.

WHAT IS THE NAME, STREET ADDRESS AND PHONE NUMBER OF YOUR PHARMACY?

NAME ___________________________________________ PHONE NO. ___________________________

ADDRESS __________________________________________

________________________________________

________________________________________

Do you take prescription blood thinners? ☐ yes ☐ no

Do you take aspirin or anti-inflammatory medicines every day? ☐ yes ☐ no

Do you have any heart valve problems? ☐ yes ☐ no

Have you had a joint or heart valve replacement? ☐ yes ☐ no

Have you been told by a doctor or dentist to take antibiotics before you have your teeth cleaned or dental work done? ☐ yes ☐ no

Are you allergic to latex? ☐ yes ☐ no

Are you allergic to intravenous contrast (dye)? ☐ yes ☐ no

What is (are) the reason(s) for your visit today? _______________________________________________

___________________________________________________ ___________________________________

PLEASE LIST YOUR MEDICATION ALLERGIES REACTION ☐ NO ALLERGIES THAT I KNOW OF

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Other allergies __________________________________ __________________________________

PLEASE LIST YOUR MEDICATIONS, PRESCRIPTION, OVER-THE-COUNTER, AND HERBAL ☐ I TAKE NO MEDICATIONS

For each medication, please tell us the dose and how often you take it

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

 PLEASE TELL US ABOUT YOUR MEDICAL HISTORY ☐ NO SIGNIFICANT MEDICAL HISTORY

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________
GEORGIA UROLOGY, P.A.
ADMISSION HISTORY

Name __________________________________________ Date of Birth ____________________________
Today's date __________________________________

PLEASE TELL US ABOUT YOUR SURGICAL HISTORY
☐ NO SURGICAL HISTORY

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WOMEN PLEASE COMPLETE THE FOLLOWING

Number of pregnancies _______ Number of Cesarian sections _______
Number of vaginal deliveries _______ Are you currently pregnant? ☐ Yes ☐ No
Date of last menstrual period________________________

EVERYONE PLEASE COMPLETE THE FOLLOWING

FAMILY HISTORY
☐ Blood disease
☐ BPH (Prostate enlargement)
☐ Cancer Type 1._________ 2.__________
                      Relation 1._________ 2.__________
☐ Cerebrovascular accident (stroke)
☐ Coronary artery disease
☐ Diabetes
☐ Eczema
☐ Gout
☐ Hearing impairment
Other: _______________________________________________________

SOCIAL HISTORY
Current marital status ☐ S ☐ M ☐ W ☐ D
Occupation __________________________________________

Tobacco ☐ Yes ☐ No ☐ Former
☐ Cigarettes ☐ Pipe
☐ Cigar ☐ Smokeless
☐ Chewing

Amount: ______________________________
Last drink: __________________________

Alcohol ☐ Yes ☐ No
☐ Beer ☐ Wine ☐ Liquor
☐ Daily ☐ Weekly ☐ Monthly ☐ Socially ☐ Rarely
Caffeine ☐ Yes ☐ No Caffeine per day___________
☐ Chocolate ☐ Tablets
☐ Coffee
☐ Soda
☐ Tea
**REVIEW OF SYSTEMS**

**NAME_____________________________________________**  **DATE OF BIRTH______________________**

**DATE ___________________ PLEASE CHECK ALL THAT APPLY  TODAY  **

**CONSTITUTIONAL**
- Activity change
- Decreased appetite
- Fatigue
- Fever
- Insomnia
- Irritability
- Malaise
- Night sweats
- Recent weight gain
- Recent weight loss

**GASTROINTESTINAL**
- Abdominal pain
- Change in bowel habits
- Blood in stool
- Indigestion/Heartburn
- Jaundice
- Nausea
- Reflux

**CARDIOVASCULAR**
- Infections

**RESPIRATORY**
- Pain during breathing
- Cough
- Frequent upper respiratory infections
- Bloody sputum (hemoptysis)
- Known TB exposure
- Snoring
- Wheezing

**HEENT**
- Headaches
- Vision loss
- Hearing loss
- Tinnitus
- Ear infections
- Vertigo
- Nosebleeds (epistaxis)
- Sinus infections
- Difficulty swallowing
- Sore throats

**URINARY (GENITOURINARY)**
- Back pain
- Cloudy urine
- Decreased stream
- Painful urination (dysuria)
- Flank pain
- Frequency
- Groin mass
- Blood in urine (hematuria)
- Hesitancy
- Incontinence
- Low urine output
- Get up at night to urinate (nocturia)
- Passing stone(s)
- Urinary urgency
- Excessive urination (polyuria)

**REPRODUCTIVE MALE**
- Not applicable
- Penile discharge
- Blood in ejaculate (hematospermia)
- Scrotum/testicular pain
- Scrotum/testicular mass
- History of hydrocele
- Genital herpes
- Infertility
- Decreased libido
- Erection problems

**REPRODUCTIVE FEMALE**
- Not applicable
- Pre-menopausal
- Peri-menopausal
- Menopausal
- Date of last menses

**IMMUNE SYSTEM**
- Asthma
- Contact dermatitis
- Food allergies
- "Bee" sting allergies
- Environmental allergies

**METABOLIC/ENDOCRINE**
- Cold/heat intolerance
- Excessive perspiration
- Goiter
- Infertility
- Low blood sugar (hypoglycemia)
- Excessive thirst (polydipsia)
- Excessive hunger (polyphagia)
- Excessive urination (polyuria)

**NEUROLOGIC/PSYCHIATRIC**
- Altered ability to speak (aphasia)
- Focal weakness
- Gait disturbance
- Loss of coordination
- Light-headed/dizziness
- Loss of consciousness/fainting
- Memory loss
- Numbness/tingling (paresthesias)
- Seizures
- Tremors
- Emotional disturbance

**SKIN (DERMATOLOGIC)**
- Contact allergies
- Itching (pruritis)
- Rash
- Light sensitivity (photosensitivity)
- Skin lesion/open area(s)

**BLOOD FORMING (HEMATOLOGIC)**
- Easy brusing
- Easy bleeding
- Blood clot(s) (thromboemboli)
- Low blood count(s) (cytopenias)
- Swollen glands (lymphadenopathy)

**MUSCULOSKELETAL**
- Back pain
- Bone/joint pain or swelling
- Muscle pain (myalgias)
- Rheumatologic issues
- Weakness

**SKIN (DERMATOLOGIC)**
- Contact allergies
- Itching (pruritis)
- Rash
- Light sensitivity (photosensitivity)
- Skin lesion/open area(s)

**MUSCULOSKELETAL**
- Back pain
- Bone/joint pain or swelling
- Muscle pain (myalgias)
- Rheumatologic issues
- Weakness

**BLOOD FORMING (HEMATOLOGIC)**
- Easy brusing
- Easy bleeding
- Blood clot(s) (thromboemboli)
- Low blood count(s) (cytopenias)
- Swollen glands (lymphadenopathy)

**IMMUNE SYSTEM**
- Asthma
- Contact dermatitis
- Food allergies
- "Bee" sting allergies
- Environmental allergies