TEXAS UROLOGY SPECIALISTS

Urology Specialists, P.A.

(Please Fill Out Completely)

Date: _____

Home Phone # _____
Cell Phone # _____
Work Phone # _____
E-mail:_____

Date of Birth: _____Age:_____Marital Status: M S D W Sex: Male Female

Patient Last Name: _____First:_____Middle:_____

Address: _____City:_____State:_____ZIP:_____

Patient Employer:
_____Occupation:_____

Ok to release Medical Information? ☐ **YES** ☐ **NO** (*To the following persons*)

1._____2._____3._____

Parent Name: _____ Parent Name: _____
Applies only to parents of minor children or children insured under the parents insurance

Referring Doctor _____Phone:_____

Primary Care Doctor_____ Phone: _____

Pharmacy Name / Location_____Phone:_____

Emergency Contact_____Phone:_____

Race: ☐ Caucasian □ African American □ Hispanic □ Asian/Indian/Pakistani/Sri Lankan □ Chamorran □ Chinese □ Fiji Islander □ Filipino □ Guamanian NOS □ Hawaiian □ Japanese □ Kampuchean/Cambodian □ Korean □ Laotian □ Melanesian NOS □ Micronesian NOS □ Samoan □ Tahitian □ Thai □ Tongan □ Vietnamese □
Other_____

Signature of Patient X_____

Signature of Responsible Party X_____

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Patient Name: _____ **Age:**_____ **Date:**_____

REASON FOR YOUR VISIT TODAY:

_____

_____

Have you or do you have any of the following: Check / Circle all that applies to you

☐ Heart Disease	☐ Urinary Infections
☐ High Blood Pressure	☐ Prostatitis
☐ Heart attack	☐ Kidney disease
☐ Aneurysm	☐ Emphysema / Bronchitis
☐ Mitral valve prolapse	☐ Lung Disease
☐ Blood Clots in legs	☐ Asthma
☐ Stroke	☐ Glaucoma Open or Closed
☐ Diabetes Date Diagnosed:_____	☐ Hearing loss
☐ Hyperthyroidism **or** Hypothyroidism	☐ Depression
☐ Stomach Ulcers	☐ Cancer_____
☐ Hepatitis A B Or C	
☐ Hemorrhoids	
☐ Hernia	
☐ Liver disease	

Previous Surgery / Hospitalization (LIST ALL) _____

_____

Medications: (INCLUDE OVER THE COUNTER MEDICATIONS AND HERBAL SUPPLEMENTS)

_____

_____

DRUG ALLERGIES: _____

FAMILY HISTORY

Do any of the following medical problems run in your family?

☐ Prostate Cancer	☐ Diabetes
☐ Heart Disease	☐ High Blood Pressure
☐ Arthritis	☐ Cancer Type: _____
☐ Stroke	

FEMALE PATIENTS ONLY

Are you or could you be pregnant? Yes / No # of pregnancies: _____

Date of Last Menstrual Period: _____ Type of Birth Control: _____

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SOCIAL HISTORY

Exercise: Yes / No Alcohol: Yes / No Amount: _____ Caffeine: Amount per day_____

Tobacco Usage Yes / No # of Years_____, Quit _____

Employment: _____Occupation:_____

UROLOGICAL HISTORY:

(PLEASE CHECK ALL THAT APPLY)

☐ Urological Surgeries / Problems, Please List _____
_____

☐ Any pain or burning when voiding / urinating?
☐ Any urgency or need to run to the bathroom?
☐ Any Urinary frequency or need to void many times during the night?
☐ Any sense of incomplete emptying of your bladder?
☐ Any leakage of urine?
☐ Any blood in urine?
☐ Any pain? If yes, where is your pain located? _____

DO NOT WRITE BELOW THIS LINE

_____/_____

(FOR PHYSICIAN USE ONLY) **VITALS: T BP P R WT**

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Patient Name: _____Age:_____Date:_____

REVIEW OF SYSTEMS: PLEASE CHECK ALL THAT YOU CURRENTLY HAVE

CONSTITUTIONAL
- ☐ FEVER
- ☐ CHILLS
- ☐ WEIGHT CHANGE

EYES
- ☐ BLINDNESS
- ☐ DOUBLE VISION
- ☐ BLURRED VISION
- ☐ BURNING
- ☐ GLAUCOMA OPEN / CLOSED

IMMUNOLOGICAL
- ☐ FOOD SENSITIVITY
- ☐ ASTHMA
- ☐ RECENT VACCINATIONS

NEUROLOGICAL
- ☐ TREMORS
- ☐ DIZZINESS
- ☐ HEADACHES
- ☐ SEIZURES
- ☐ NUMBNESS / TINGLING

ENDOCRINE
- ☐ HEAT / COLD INTOLERANCE
- ☐ INCREASED THIRST
- ☐ FREQUENT URINATION
- ☐ HAIR LOSS
- ☐ TIRED / SLUGGISH

GASTROINTESTINAL
- ☐ ABDOMINAL PAIN
- ☐ DIARRHEA
- ☐ NAUSEA / VOMITING
- ☐ CONSTIPATION
- ☐ INDIGESTION / HEARTBURN
- ☐ BLOATING

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ IRREGULAR HEART BEAT
- ☐ ANKLE SWELLING
- ☐ HEART FAILURE

MUSCULOSKELETAL
- ☐ MULTIPLE JOINT SWELLING
- ☐ GOUT
- ☐ MULTIPLE FRACTURE
- ☐ NIGHT CRAMPS
- ☐ NECK PAIN
- ☐ BACK PAIN

EAR, NOSE, THROAT
- ☐ RINGING IN THE EARS
- ☐ HEARING LOSS
- ☐ HOARSENESS
- ☐ SORE THROAT
- ☐ RECURRENT NOSE BLEEDS
- ☐ MOUTH ULCERS
- ☐ EAR INFECTION

URINARY
- ☐ PAINFUL URINATION
- ☐ URINARY FREQUENCY
- ☐ BLOOD IN URINE
- ☐ LOSS OF BLADDER CONTROL
- ☐ URINARY DISCHARGE

RESPIRATORY
- ☐ COUGH
- ☐ SHORTNESS OF BREATH
- ☐ COUGH WITH BLOOD
- ☐ WHEEZING

HEMATOLOGIC
- ☐ SPONTANEOUS BLEEDING
- ☐ BRUISING
- ☐ ENLARGED LYMPH NODES
- ☐ ANEMIA
- ☐ JAUNDICE

PSYCHOLOGICAL

ARE YOU GENERALLY SATISFIED WITH YOUR LIFE?
☐ YES ☐ NO

DO YOU FEEL SEVERLY DEPRESSED?
☐ YES ☐ NO

HAVE YOU EVER CONSIDERED SUICIDE?
☐ YES ☐ NO

TEXAS UROLOGY SPECIALISTS
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Urology Specialist is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of you health information by our practice and outlines your rights with regard to your health information. **Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.**

I acknowledge that I have received a copy of the Notice of Privacy Practice of Texas Urology Specialists.

Name: (Please Print) _____

Signature: _____

Name of Personal Representative: (if appropriate) _____

Signature of Personal Representative: (if appropriate) _____

Date: _____

(Texas Urology Specialists) Use Only
Date acknowledgement received: _____

-Or_

Reason acknowledgement was not obtained:
_____
_____
_____
_____
_____

TEXAS UROLOGY SPECIALISTS

Urology Specialists, P.A.

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Texas Urology Specialists for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice's health care operations. I understand that diagnosis or treatment of me by Dr. Steven W. Sukin or Dr. Penner Schraudenbach or Dr. Miguel Mercado may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" encompasses health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This is protected health information relates to my past, present or future physical or mental health and identifies me or provides reasonable basis for identifying me.

I understand I have the right to request a restriction as to how my protected heath information is used or disclosed to carry out treatment, payment or the practices healthcare operations. Urology Specialists is not required to agree to the restrictions that I may request, however if Texas Urology Specialists agrees to a requested restriction, that restrictions binding on both the practice and the attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Texas Urology Specialists has taken action in relevance on this consent.

I understand I have a right to review Texas Urology Specialists ***Notice of Privacy Practices*** prior to signing this document. This Notice of Privacy Practices has been provided to me and is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or the performance of health care operations of Urology Specialists. It also describes my rights and Texas Urology Specialists duties with respect to my protected health information.

Texas Urology Specialists reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize Texas Urology Specialists to call my home or work to remind me of an appointment or to reschedule an appointment. I also authorize Texas Urology Specialists to leave scheduling information on my answering machine, or voicemail system.

X_____ X _____

Signature of Patient or Personal Representative Date

X _____

Printed name of Patient or Personal Representative

X _____

Description of Personal Representative's Authority

TEXAS UROLOGY SPECIALISTS
STEVEN W. SUKIN, M.D.
PENNER SCHRAUDENBACH, M.D.
506 GRAHAM DR. #150
TOMBALL, TEXAS 77375
PHONE: 281-351-5174 FAX: 281-351-5172

Authorization Request for Medical Records

I hereby authorize use or disclosure of protected health information about me as described below

I _____ authorize Steven W. Sukin, M.D., Penner Schraudenbach, M.D. or Dr. Miguel Mercado, M.D., to request any and all medical information from the following persons and or facilities.

Physician/Facility _____

Address: _____

_____

Telephone: _____

Fax: _____

Specific description of information requested.

For the purpose of □ Continued Care □ Attorney/Legal □ Personal use □ Insurance □ Other

Please release the following:

- ☐ Problem List
- ☐ Progress Notes
- ☐ History/Physical Exam
- ☐ Medication List
- ☐ Immunization Record
- ☐ List of Allergies
- ☐ X-Ray/Imaging Reports
- ☐ X-Ray Films
- ☐ Laboratory Results from
- ☐ EKG Reports
- ☐ Genetic Testing Information
- ☐ Other Diagnostic Reports (Specify) _____

Other (Specify) _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying Urology Steven W. Sukin, MD desire to revoke it. However I understand that nay action already taken in advance of this authorization cannot be reversed and y revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____	_____
Signature of Individual	Date of Signature	Date of Birth or SS #

Or if applicable

_____	_____	_____
Signature of Guardian	Date of Signature	Description of Guardian

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PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide Texas Urology Specialists access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Texas Urology Specialists may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Texas Urology Specialists, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read this form or it has been read to me.

Date: _____

Print Name (Patient):_____ **DOB:** _____

Signature of Patient/Legally Authorized Representative:

_____

Relationship to Patient (if Patient not signing):

_____

For patients requiring translation or verbal reading of this document, the person Reading or translating should document and sign below:

Reader/Translator Signature: _____ Date: _____

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CANCELLATION & NO-SHOW POLICY

We strive to render excellent medical care to you and the rest of our patients, so we understand that situations arise in which you must cancel your appointment. In order to provide all of our patients with the highest level of care and access we request that all patients that need to cancel their appointment provide more than 24-hours notice. This will enable us to better utilize available appointments for our patients.

Appointments cancelled with less than 24-hours or if the patient No-shows without notification may be subject to a cancellation fee. The cancellation fees are provided below based on type of appointment:

Office visits	$50.00
In-office Procedures	$100.00
Hospital procedures	$250.00

The Cancellation and No-show fees are the sole responsibility of the patient and must be paid in full before the patients next scheduled appointment.

Please contact our office should you have any questions regarding the Cancellation and No-show fees and we will be glad to assist.

_____ _____

Patient Name (please print) **Date of Birth**

_____ _____

Patient Signature or Patient Representative **Date**