

PATIENT INFORMATION SHEET & QUESTIONNAIRE

Date: _____ Home Phone: _____
 Patient Name: _____
 Person Responsible for Acct: _____
 Patient Address: _____ Apt. # _____
 City: _____ State: _____ Zip: _____
 Age: _____ Birthdate: _____ (Sex: M F Marital Status: S M W D Separated
 Social Security Number: _____ (For above, circle appropriate answer)

Is patient a student: Yes No Patient's Occupation: _____
 Name of Employer: _____ Address of Emp: _____
 Work Phone: _____ City: _____ State: _____ Zip: _____
 Name of Spouse: _____ (If pt. is child, give name of husband/wife)
 Spouse Employer: _____ City: _____ State: _____ Zip: _____

In case of emergency, and we need to contact nearest relative, please give name and address of nearest relative:
 Name: _____ Relationship to pt: _____
 Address: _____ City: _____ Phone: _____

Medical/Surgical Insurance

Primary Ins. Company: _____ ID # _____ Grp # _____
 Is this group insurance? Yes No Name of subscriber: _____
 *Name of company who carries this ins: _____
Secondary Insurance: _____ ID # _____ Grp # _____
 Is this group insurance: Yes No Name of Subscriber: _____
 Name of company who carries this ins: _____

HAVE YOU EVER HAD ANY OPERATIONS OF ANY KIND; IF SO, PLEASE LIST AND GIVE APPROXIMATE DATES:

HAVE YOU EVER HAD, OR BEEN TREATED FOR, ANY OF THE FOLLOWING:

	Yes	No		Yes	No	
Blood in urine	_____	_____	High blood pressure	_____	_____	Referring physician: _____
Kidney stones	_____	_____	Heart disease	_____	_____	Family physician: _____
Kidney infections	_____	_____	Diabetes mellitus	_____	_____	E.N.T. _____
Bladder trouble	_____	_____	Epilepsy	_____	_____	Surgeon _____
Prostate trouble	_____	_____	Venereal disease	_____	_____	Gyn _____
Diagnosis of cancer	_____	_____	Stomach ulcer	_____	_____	Cardiologist/Int. _____
Chest pain	_____	_____	Shortness of breath	_____	_____	Other: _____

Any family history of the above:
 Mother: _____
 Father: _____

How many packs of cigarettes per day have you smoked (for how many years)? _____
 How much alcohol consumption per day? _____

LIST ANY CURRENT MEDICATIONS YOU TAKE, EITHER NOW OR ON A REGULAR BASIS, SUCH AS ASPIRIN, HIGH BLOOD PRESSURE MEDICATION, EPILEPSY MEDICATION, ETC.: _____

DRUG/ALLERGIES: _____

HAVE YOU EVER HAD REACTION TO SEAFOOD? _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE ATLANTA UROLOGICAL GROUP, P.C., TO FURNISH INFORMATION TO ANY INSURANCE CARRIER CONCERNING MY ILLNESS AND TREATMENT(S) HERE, AND I HEREBY AUTHORIZE ASSIGNMENT OF BENEFITS FOR MEDICAL/SURGICAL SERVICES RENDERED BY ATLANTA UROLOGICAL GROUP TO BE PAID DIRECTLY TO THE DOCTOR ON SERVICES RENDERED EITHER TO MYSELF OR MY DEPENDANTS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE.

Date: _____ Signature: _____

*****THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES ***** WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.