PATIENT HISTORY FORM

Last Name ________________________ First Name ______________________ MI _______

Date of Birth _______/_______/_______

Referring Doctor ________________________ Family Doctor _________________________

Pharmacy Name ______________________ Pharmacy Phone Number (____)_____-_________

Chief Complaint (Reason for visit today – describe in detail)

List all medical problems such as diabetes, heart disease, high blood pressure, cancer, etc.

List all previous surgeries and when they occurred.

List all previous hospital admissions – when and what for

Do you smoke (if yes how much and how long)? ____

Do you drink alcohol (if yes how much and how long)? ____________________________________

Has anyone in your family been diagnosed with bladder cancer, kidney cancer, prostate cancer, kidney stones (If yes please explain)?

List any medications you are taking (including over the counter medications)

____

____

____

List any drug allergies and explain your allergic reaction.

____

____

At the present time do you have any problems related to the following systems?

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Weight gain/loss	Y	N

Eyes

Double Vision	Y	N
Pain	Y	N
Blurred Vision	Y	N

Ear/Nose/Throat/Mouth

Sinus Problems	Y	N
Sore Throat	Y	N
Ear Infection	Y	N

Respiratory

Shortness of Breath	Y	N
Frequent Cough	Y	N
Wheezing	Y	N

Gastrointestinal

Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N
Abdominal Pain	Y	N

Genitourinary

Urinary Frequency	Y	N
Painful Urination	Y	N
Urine Retention	Y	N

Musculoskeletal

Back Pain	Y	N
Neck Pain	Y	N
Joint Pain	Y	N

Skin

Boils	Y	N
Persistent Itching	Y	N
Rash	Y	N

Neurologic

Numbness/Tingling	Y	N
Dizzy Spells	Y	N
Tremors	Y	N

Endocrine

Tired/Sluggish	Y	N
Too hot/cold	Y	N
Excessive Thirst	Y	N

Hematologic/Lymphatic

Blood Clotting problem	Y	N
Swollen Glands	Y	N

Allergic/Immunologic

Drug Allergies	Y	N
Hay Fever	Y	N

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel depressed?	Y	N

REGIONAL UROLOGY, PLLC
DR. DAVID C. OWENS

First name______________________ MI____ Last name___________________________

DOB ____/____/_____ Age _______ Sex _______ SS number_______-________-________

Mailing address____

City___________________________________ State_______________ Zip________________

Mobile (_____) _____-______ Home (_____) _____-_______ Work (_____) _____-_______

Employer ____

Circle preferred contact number: Mobile Home Work

Circle preferred contact method for appointment reminders: Text Voice Call Both None

Spouse's full name_______________________________________ DOB_____/_____/_____

Spouse's SS #_____-_____-_____ Spouse's phone (____) _____-_________

Spouse's employer____ Phone (____) ____-_______

Emergency contact _______________________________________ Phone (____) ____-______

Insurance Information:

Primary insurance____________________________ Policy Number_____________________

Name of policy holder:___________________________ Date of Birth______/______/______

Secondary insurance____________________________ Policy Number____________________

Name of policy holder____________________________ Date of Birth______/______/______

Please sign below for authorization of treatment and release of information that may be necessary for insurance purposes.

Signature: _____________________________________ Date: __________________________

REGIONAL UROLOGY, P.L.L.C.
DR. DAVID C. OWENS

AUTHORIZATION/RESPONSIBILITY AGREEMENT – CONSENT FOR TREATMENT

THIS IS TO CERTIFY THAT THE UNDERSIGNED AUTHORIZES THE EXAMINATION, OPERATION OR TREATMENT AS MAY BE NECESSARY OR ADVISABLE BY REGIONAL UROLOGY, P.L.L.C.

1. I, the undersigned as the patient or his/her authorized representative, do hereby authorize **Regional Urology, P.L.L.C.** to release to my insurance company or other appropriate agency that information which is necessary to validate this claim. **Regional Urology, P.L.L.C.** is also hereby authorized to release to any other physician, either as individuals or as a professional association, who perform services for me, such information as is necessary for billing purposes.

2. I hereby authorize any insurance company to pay the proceeds of any benefits due to me directly to **Regional Urology, P.L.L.C.** A copy of this can be considered as an original for insurance purposes. All co-pays, deductibles and out-of-pocket payments must be paid at the time of service.

3. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

4. If this bill is not paid within a ninety (90) day period from demand or billing, **Regional Urology, P.L.L.C.** may turn the collection of this account over to a collection agency or an attorney. I, the undersigned, accept a 50% additional fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, attorney fees and/or court costs, if such be necessary. I wave now and forever my rights of exemption under the laws of the constitution of the State of Mississippi and any other State.

5. I, the undersigned, give **Regional Urology, P.L.L.C.**, its employees and/or agents express prior consent to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance or payment.

6. My signature at the bottom of this page represents that I have read this agreement and understand the contents.

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFTIS TO PHYSICIAN

I request that payment of authorized insurance benefits be made on my behalf to **Regional Urology, P.L.L.C.** for services furnished to me by physicians associated with **Regional Urology, P.L.L.C.** I authorize **Regional Urology, P.L.L.C.** to release Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

______________________________	______________________________
Signature	Date

REGIONAL UROLOGY, P.L.L.C.
1133 OCEAN SPRINGS ROAD
OCEAN SPRINGS, MS 39564

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Use and Disclosure of your Protected Health Information
Your protected health information will be used by **Regional Urology, P.L.L.C.** or disclosed to others for purpose of treatment, obtaining payment, or supporting day to day health care operations of the practice.

Please list below any individuals that you give permission to receive your protected health information such as family members or friends. (This page is not intended for the release of information to other physicians.)

Name: ____ Relationship: __________________________

Name: ____ Relationship: __________________________

Name: ____ Relationship: __________________________

(If more space is needed please list on the back of this page.)

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a restriction on the use or disclosure of your protected health information
Regional Urology, P.L.L.C. may or may not agree to restrict the use or disclosure of your health information. If **Regional Urology, P.L.L.C.** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of right to change privacy practices
Regional Urology, P.L.L.C. reserves the right to modify the privacy practices outlined in this notice.

Signature
I have reviewed this consent form and give my permission to **Regional Urology, P.L.L.C.** to use and disclose my health information in accordance with it.

Printed name of patient: ____

Patient/guardian signature: ____

Date: ____________________________