Southeast Georgia Urology Associates

2500 Starling St #406
Brunswick, GA 31520

Telephone: (912 261-0447
Fax: (912 261-1847

PATIENT INFORMATION FORM

Patient Name: Last First MI Spouse's Name:

Patient Address: Home Phone: Best time to contact by phone:

City: State: Zip: Cell Phone:

Email Address:

Birthdate: / / **SS#:** - - Height: Weight:

Employer: Position: Address: Work Phone: ext:

Preferred Urology Office Location: Brunswick St. Marys

Age: **Sex:** Male Female **Race:** White Black Asian Hispanic Other

Preferred Pharmacy:______________________________ Phone:___________________ Fax:___________________

City:_________________________ State:_______ Zip:___________

Primary Care Provider:

Referring Provider:

Reason for Appointment today (Chief Complaint)

	PRIMARY INSURANCE			**: SECONDARY INSURANCE**		
	Month:	Day:	Year:	Month:	Day:	Year:
Name of Insured						
Insured Birthday						
Relation to Insured						
Insurance Company						
Address Line						
Address Line2						
Policy						
Group						
Deductible Amount						
Co-payment amount						

Please deliver or fax completed form to our office prior to your appointment. Fax number: 912.261-1847

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MEDICAL AND SOCIAL HISTORY

Please circle all that apply, write in any additional items not listed. If None apply, please circle 'None'

Marital Status: Married Single Divorced Separated Widow Widower

Smoking History: Non-smoker ½ pack a day 1 pack a day 1 ½ packs a day 2 packs a day or more
Number of years you have been smoking? Number of years since you quit smoking

Alcohol Use: social/occasional usage Light usage moderate usage heavy usage never drinks alcohol
Recovering alcoholic alcoholic not in recovery

Do you drink coffee? Yes No **If so, how much?** ______
Do you drink tea? Yes No **If so, how much?** ______
Do you drink soft drinks? Yes No **If so, how much?** ______
Do you eat chocolate? Yes No **If so, how much?** ______

Are you on a special diet? (If yes, describe)

Occupation:

Significant Family Medical History:

Current Medications:

MEDICATION	***DOSAGE***	***TIMES A DAY***	***DATE YOU STAR TED THIS MEDICATION***

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Allergies: **If none…. Please write in "NONE"**

Aspirin Bactrim Cipro Codeine Codine	Compazine Demerol Erythromycin Fish Floxin	Iodine IVP Dye Keflex Levaquin	Macrobid Morphine Penicillin Seafood	Sulfa Drugs Talwin Tetracycline Vasotec

Major Surgeries: **If none…. Please write in "NONE"**

Major Injuries: **If none…. Please write in "NONE"**

Automobile accident	Head injury	Severe back injury.	Trauma to kidneys.	

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REVIEW OF SYSTEMS

Constitutional	**Y**	**N**
Fever		
Chills		
Headache		
Other		

Eyes	**Y**	**N**
Blurred Vision		
Double Vision		
Pain		
Other		

Allergic Immunologic	**Y**	**N**
Hay Fever		
Drug Allergies		
Other		

Neurological	**Y**	**N**
Tremors		
Dizzy Spells		
Numbness/Tingling		
Other		

Endocrine	**Y**	**N**
Excessive thirst		
Too hot / too cold		
Tired/sluggish		
Other		

Gastrointestinal	**Y**	**N**
Abdominal pain		
Heartburn		
Indigestion		
Nausea/vomiting		
Other		

Cardiovascular	**Y**	**N**
Chest pain		
High Blood pressure		
Varicose veins		
Other		

Integumentary	**Y**	**N**
Rash		
Boils		
Persistent Ich		
Other		

Ear Nose Throat Mouth	**Y**	**N**
Ear Pain		
Sinus Infections		
Sinus Problems		
Other		

Musculoskeletal	**Y**	**N**
Back Pain		
Neck Pain		
Other		

Genitourinary	**Y**	**N**
Urine Retention		
Painful Urination		
Uninary Frequency		
Other		

Respiratory	**Y**	**N**
Wheezing		
Frequent Cough		
Shortness of breath		
Other		

Hematologic/Lymphatic	**Y**	**N**
Swollen Glands		
Blood Clotting Problems		
Other		

Psychologic	**Y**	**N**
Are you generally satisfied with your life		
Do you feel severely depressed		
Have you considered suicide		
Other		

By signing below I acknowledge that all information on this document is true and complete to the best of my knowledge, and that I understand that this information may be related to my insurance company(s) for processing.

____

Signature (Parent if Minor) Date

Southeast Georgia Urology Associates

FINANCIAL, INSURANCE, AND PRIVACY POLICIES

Payment is due at the time of service. However, as a service to our patients, we will be happy to file your primary and secondary insurance for you. At the time services are rendered, the patient is responsible for payment of the portion their insurance company does not normally pay (ie: your deductible, co-payment, and the percent of the bill not generally covered by insurance.) Once the patient's insurance company has paid their portion, or after we have waited for their payment for 30 days, you will be billed for any remaining charges not yet paid in full.

Each insurance company sets different standards for treatment and reimbursement. Although the majority of our charges fall within most insurance companies' usual customary and reasonable rates, our charges are not based on any one insurance company's fee scale. The patient is financially responsible for any charges not covered by their insurance.

Any medical referral forms, confirmation of insurance coverage, pre-certification, and/or notification of the patient's insurance company are the patient's responsibility. The patient is financially responsible for any charges not covered by their insurance due to failure to obtain the appropriate referral forms / pre-certification, or prior insurance company approval.

PATIENTS NOT FILING INSURANCE

Patients who do not have insurance, do not have proof of current insurance, or do not want us to file their insurance must pay the full balance at the time of service, unless other payment arrangements are made in advance of seeing the doctor. If you do not have insurance, and do not have full payment, please ask to see the office manager before your appointment to make payment arrangements.

LAB SERVICES / Insurance Coverage

Urine and blood specimens are frequently taken during office visits in our facilities, and these specimens are frequently forwarded to an outside, certified lab for analysis. Each insurance company sets different standards for which lab tests they will pay for, and some insurance companies / policies list particular laboratories that they require specimens be sent to receive full coverage (Medicare has no such requirement). If your insurance policy has such a requirement, it is your responsibility to notify the nurse and / or office staff in writing before your appointment.

For the convenience of our patients, we accept payment by VISA, MasterCard, checks, and cash.
I have read and agree to the FINANCIAL POLICY above.

____
Signature (Parent if Minor)   Date

INSURANCE AUTHORIZATION

I hereby authorize Southeast Georgia Urology Associates, its physicians and staff to release any information to any insurance company processing my claim, including the diagnosis and records in the course of my examination or treatment. I hereby authorize payment directly to Southeast Georgia Urology and/or its physicians of the medical and/or surgical benefits otherwise payable to me but not to exceed the charges made for such treatment. A photocopy of this document is as valid as the original.

____
Signature (Parent if Minor)   Date

HIPPA AUTHORIZATION

By signing this form I acknowledge that I have been given the opportunity to review the above named office's Notice of Privacy Practices, and informed I may keep a copy for reference or obtain a copy upon request.

____
Signature (Parent if Minor)   Date