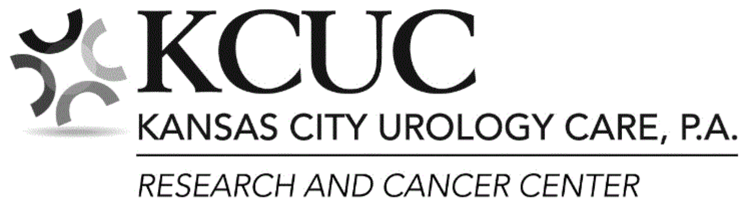

Urologist

Frank J. Albani ,MD
Justin M. Albani, MD
Mark S. Austenfeld, MD
Nathaniel K. Ballek MD
David B. Bock, MD
David F. Emmott, MD
Kent L. Haggard, MD
Thomas B. Herrick, MD
Lindsay Hertzig MD
Christian A. Hettinger MD
Daniel G. Holmes, MD
Gregory J. Horwitz, MD
Brandan A. Kramer, MD
Samuel Kuykendall, MD
James S. Magera Jr.., MD
Scott A. Montgomery, MD
Steven D. Nash, MD
Son T. Nguyen, MD
Gerald Y. Park, MD
Brandon D. Pomeroy, MD
John T. Strickland, MD
Susan D. Sweat, MD
Douglas N. Tietjen, MD
Scott Johnson, PA-C
Jamie Mehl, MSN, ANRP
Allison Serrano, PA-C
Nicole Valdivia, ANRP
Brice Weber, PA-C

Pathologist

Russell L Benson, MD

Radiation Oncologists

Stephen Smalley, MD
Kelly Rhoades Stark, MD

Appointment Date/Time: ____

Provider:____

Office Address:____

Dear _____________________________,

Thank you for entrusting Kansas City Urology Care, PA with your urologic care. Our physicians and office staff are eager to serve you.

In order to provide you with the best services possible, we ask that you please complete the enclosed paperwork and bring it with you to your appointment.

- **Please arrive 15 minutes early for your appointment. If your paperwork has not been completed, please arrive 30 minutes before your appointment or we reserve the right to reschedule your visit.**
- **If you have had any x-rays, CT scans, MRI's, bone scan or any records that pertain to your urology needs, please bring your films with you at the time of your appointment.**
- Please bring your insurance cards and medication list with you.
- Please be prepared to pay your co-pay at the time of your visit
- If your insurance requires a written referral to see a urologist (specialist), please bring a referral form completed by your primary care physician at the time of your visit. If you arrive without a valid referral form we reserve the right to reschedule your appointment because of your insurance requirements.
- **Self-pay patients please come prepared to make payment in full at the time of your visit. If you pay in full at the time of service your charge will be discounted 30%. If you cannot pay in full please be prepared to render a minimum of $100.00, we will bill you for the additional charges.**
- **Please be advised that a NO SHOW fee of $25 will apply if you fail to cancel or reschedule your appointment 24 hours prior.**

Thank you for your assistance in helping us expedite your appointment.

4321 Washington #5300, Kansas City, Mo 64111
23401 Prairie Star Parkway, Lenexa, Ks 66227
301 NE Mulberry #200, Lee's Summit, Mo 64086
17067 S 71 Hwy #200, Belton, Mo 64012
2529 Glenn Hendren Dr #202, Liberty, Mo 64068
5844 NW Barry Rd #300, Kansas City, Mo 64154

9301 W 74th Street #225, Merriam, Kansas 66204
10701 Nall Ave #100, Overland Park, Ks 66211
6400 Prospect #228, Kansas City, Mo 64132
2750 Clay Edwards Dr #500, North Kansas City, Mo 64116
2700 Clay Edwards Dr #300, North Kansas City, Mo 64116
8551 Bluejacket St, Lenexa, Ks 66214

Patient Financial Policy

Thank you for choosing Kansas City Urology Care, PA as your urology health care provider. We are committed to providing you with the highest quality medical care, in a supportive, empathetic and respectful manner. If you have special needs, we are here to work with you.

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Your clear understanding of our "Patient Financial Policy" is important to our professional relationship. Please ask if you have any questions about our fees, our policies or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date.

Insurance

It is the patient's responsibility to provide the clinic with current insurance information since our practice participates with a variety of insurance plans. **Your insurance policy is a contract between you and your insurance company.** We consider an insurance card similar to a credit card because you are asking us to bill another party (your insurance) for charges for the services you have been provided.

As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account.**

If we DO participate with your insurance company, all services performed in our office will be submitted to them, unless we have received prior notification of non-covered services. All copays and deductibles are the patient's responsibility. Copay's are due at the time of service.

If we DO NOT participate with your insurance company, we will file the insurance claim and accept the payment, but we will not accept the contractual adjustment. That balance will be the patient's responsibility and any balances that are not covered will be the patient's responsibility.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to know if a certain procedure is not covered, please check your insurance handbook.

It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.

Co-pays

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, check, or creditcard (MasterCard, VISA, AMEX or DISC). If you do not bring proper payment to your visit, you may be asked to reschedule your appointment except in the case of a medical emergency.

Patients with NO Medical Insurance

If you do not have group or individual medical insurance, payment for professional services is expected at the time of service. As a courtesy, the practice offers a 30% discount of billed charges, to anyone with no insurance if paid at the time of service. This discount is available **ONLY ON** the actual date of service.

If unable to pay at the time of service, at the discounted rate (30% of billed charges), we require a $100 down-payment toward all billed services, which will be at the full fee amount. If you have questions, we would recommend that you contact our billing department (913-341-7985) prior to your appointment.

Waiver of Patient Responsibility

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to make reasonable collection efforts, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the Kansas City Urology Care's Charity Care Policy.

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Un-Paid Balances & Payment Arrangements

If your insurance company has not paid the balance in full or you are unable to pay the balance in full, you will receive a statement notifying you of the amount due, you may call our billing office at (913)-341-7985 to set up payment arrangements if necessary. If you fail to make payment in full, within 120 days, for the services that are rendered to you, your outstanding balance may be considered for further collection activity.

Late Arrivals

A late arrival, not considered to be the responsibility of Kansas City Urology Care, will be registered and worked into the schedule as soon as possible. If the patient is more than 30 minutes late, the appointment may be rescheduled.

No-Shows

Kansas City Urology Care, PA may charge a $25 "no-show" fee in the event that you do not show for your appointment and in which you do not cancel or reschedule with 24 hours' notice. This will be applied to your account.

Returned Checks

The charge for a returned check is $30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a "Cash Only" basis following any returned check.

Minors

Our practice does not treat minors without the presence of a parent(s) or guardian(s). If the patient is a minor (under 18 years of age), the parent(s) or guardian(s) is responsible for full payment and will receive the billing statements.

Divorce Decrees

Kansas City Urology Care is not party to any divorce decrees, so any outstanding balance is still the responsibility of the patient or the legal guarantor of the patient, in the case of a minor.

Special Form Fees

If you require any special forms to be completed (for example; FMLA, Work Comp or Disability) by a physician, the patient/guarantor will be responsible for any fees related to the service.

Medical Record Copies

Your medical record is the property of Kansas City Urology Care, PA. If you would like to request a copy of your medical records, for yourself or to be mailed to another provider, please contact your physician's office to obtain the proper Medical Records Request form.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Kansas City Urology Care may charge a reasonable cost-based fee pursuant to 45 CFR 164.524. Kansas City Urology Care has developed a fee structure that is slightly below the Missouri and Kansas Department of Health Services maximum standards:

- Clerical fees $18.50
- For the first 250 pages $ 0.50 per page (maximum $125.00)
- For each page after 250 $ 0.45 per page
- Plus actual postage

Kansas City Urology Care must emphasize that as healthcare providers, our relationship is with you, not your insurance company. While filing the insurance claims is a courtesy we extend to our patients, all charges are strictly your responsibility from the time services are rendered. Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier. We do realize that temporary financial problems may affect timely payment, but if such problems do arise, we encourage you to contact us promptly for assistance in the management of your account at 913-341-7985.

Kansas City Urology Care believes that a good patient-to-physician relationship is based upon understanding and good communication. Thank you for understanding our "Patient Financial Policy". We appreciate the opportunity to provide you with your urological care. Your assistance and cooperation will be most appreciated.

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PATIENT INFORMATION

Patient Name: ____ Date: ________________

Address: ______________________________ City/State:__________________________ Zip: _______

Date of Birth: ____________ Age: ___ Race: __________________ Male or Female (circle one)

Social Security #: __________________ Marital Status S__ M__ D__ W__ No. of Children: ______

Home Phone: _______________ Cell Phone: _______________ e-mail: __________________________

Employer: ____ Work Phone: ___________________

Are you currently residing in a Nursing facility? Yes __No __ If Yes, what facility? __________________

Facility Address: ____ Facility Phone: __________________

Are you currently being cared for by Hospice or a Home Health Agency for another condition? Yes __ No __

If Yes, what Agency? ________________________________ Agency Phone: ______________________

Agency Address: ____

REFERRING DOCTOR / PRIMARY CARE DOCTOR

Referred to KC Urology by: ________________________ Referring Provider Title (circle one): MD DO NP PA

Address: ____Suite:____________

City/State/Zip: ____ Phone: ___________________

Primary Care Physician: __________________________ Referring Provider Title (circle one): MD DO NP PA

Address: ____Suite:____________

City/State/Zip: ____ Phone: ___________________

PATIENT INSURANCE INFORMATION (must be completed)

____
Primary Insurance Company ID # Plan # Group #

____
Insured's Name Relationship to Patient Contact Phone # Date of Birth

____
Secondary Insurance Company ID # Plan # Group #

____
Insured's Name Relationship to Patient Contact Phone # Date of Birth

(This page must be completed)

____
(Patient Name)

PATIENT EMERGENCY CONTACT INFORMATION – NOT LIVING WITH YOU

Name: ____________________ Phone: ________________ Relationship to Patient: ________________

Name: ____________________ Phone: ________________ Relationship to Patient: ________________

PREFERRED PHARMACY – we are implementing electronic prescribing, please provide the following information

PRIMARRY PHARMACY

Primary Pharmacy Name: ________________________ Address: ________________________

City/State/Zip: ________________________________ Phone #: ________________________

SECONDARY/MAIL ORDER PHARMACY

Primary Pharmacy Name: ________________________ Address: ________________________

City/State/Zip: ________________________________ Phone #: ________________________

ALTERNATE LOCAL/MAIL ORDER PHARMACY

Primary Pharmacy Name: ________________________ Address: ________________________

City/State/Zip: ________________________________ Phone #: ________________________

PATIENT SPOUSAL / PARENT CONTACT INFORMATION

Name: ____SS#:____________________________
First MI Last

Address: ______________________________City/State/Zip: ______________________________

Home Phone: ________________ Relationship to Patient: ___________ Date of Birth ____________

VISIT DUE TO AN ACCIDENT

Is this visit due to an accident? Yes __ No __ If Yes: Auto __ Work ___ Other __

Date of Accident: ___________ Explain nature of accident: ______________________________

____

Were x-rays done for this condition? Yes __No __ Date: ___________ Where: ______________________

____
(Patient Name)

INSURANCE CONSENT

I hereby authorize release of information to my insurance companies and payments to be made directly to my physicians. This form may be used for all of my insurance companies, and I authorize this practice to act as my agent to help me secure payment from my insurance companies. I understand that I am responsible for my bill and am subject to attorney fees, collection fees/charges, and any other charges incurred if my portion of the balance is not paid when due.

____
Initials

MEDICAL RECORDS RELEASE AUTHORIZATION

I authorize the Kansas City Urology Care, PA to release to any person, corporation, or other entity any diagnostic and therapeutic information (including any treatment for alcohol or drug abuse and any psychiatric or psychological treatment) as may be necessary to determine health care benefits entitlement for me under any insurance policy or other type of health care benefits plans or as may be appropriate for the purpose of analysis or research regarding reimbursement of doctors and other health care providers. I authorize Kansas City Urology Care, PA to process payment claims for health care services provided to me. I agree to cooperate and execute such other authorizations and releases for the above purposes as deemed necessary by Kansas City Urology Care, PA upon the practice's request. Kansas City Urology Care, PA may utilize information in my medical record that is necessary for research for quality improvement purposes.

____
Initials

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations set forth in the Health Insurance Portability & Accountability Act of 1996 (HIPAA), Kansas City Urology Care, PA has issued a Notice of Privacy Practice (Notice) to the me. I acknowledge I been given a copy of the Notice, which describes how a patient's health information is used and shared. I understand that Kansas City Urology Care, PA has the right to change this Notice at any time, and if the Notice changes, a current copy may be obtained by contacting Kansas City Urology Care, PA or by visiting the Kansas City Urology Care, PA website.

____
Initials

FINANCIAL POLICY & PAYMENT GUARANTEE

I have received and read and fully understand the financial policy set forth by Kansas City Urology Care, PA and I agree to the terms of this financial policy. I agree that the terms of the financial policy may be amended by the practice at any time without prior notification to me, the patient.

____
Initials

I understand that, in consideration of the services rendered to me, I am subject to all attorney fees, collection charges, and any other changes incurred if my portion of the bill is not paid when due.

____
Initials

DME WARRANTY COVERAGE

I understand Kansas City Urology Care, PA honors all warranties of manufacturers of the equipment the practice provides.

____
Initials

MEDICARE BENEFITS CONSENT

If I am covered by Medicare, I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my, as the patient's, behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit claim to Medicare for payment to the patient.

____
Initials

Patient Signature:_______________________________________ Date:_____________________________

Witness Signature:_______________________________________ Date: _____________________________

MEDICARE SECONDARY PAYER QUESTIONNAIRE

(TO BE COMPLETED FOR **ALL** MEDICARE PATIENTS)

PATIENT NAME: ________________________________ **PATIENT MEDICARE #** _______________

If any answers to questions 1 through 4 are yes, the corresponding section of the "Other Insurance" form must be filled out completely.

	YES	NO
1. Is the patient a Veteran?	_____	_____
Did the VA refer you here for treatment?	_____	_____
Does the patient have a VA "fee basis ID Card?"	_____	_____
2. Do you have a Federal Black Lung card?	_____	_____
3. Is this medical condition due to an accident of any kind?	_____	_____

If yes was it: Work Related ☐ Auto ☐ Injured in own home ☐ Other ☐

	YES	NO
4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (Not retiree coverage)	_____	_____

(**OFFICE USE ONLY** - This section must be updated or documented for each patient visit.)

Date of Service	Initial	Date of Service	Initial	Date of Service	Initial
___________	________	___________	________	___________	________
___________	________	___________	________	___________	________

MEDIGAP AUTHORIZATION FORM

I hereby authorize payment of my Medigap benefits to Kansas City Urology Care, PA for all claims filed on my behalf. This authorization applies to all services until my representative or I revoke it.

BENFICIARY SIGNATURE: ____

MEDIGAP INSURER: ____

MEDIGAP ADDRESS: ____

____

MEDIGAP TELEPHONE #: ____

MEDIGAP POLICY #: ____

(**OFFICE USE ONLY** - This section must be updated or documented for each patient visit.)

Date of Service	Initial	Date of Service	Initial	Date of Service	Initial
___________	________	___________	________	___________	________
___________	________	___________	________	___________	________
___________	________	___________	________	___________	________

OTHER INSURANCE INFORMATION
(TO BE COMPLETED IF ANY OF THE FIRST FOUR QUESTIONS ON THE M.S.P. QUESTIONNAIRE ARE ANSWERED "YES")

VETERANS ADMINISTRATION AUTHORIZATION INFORMATION **Yes** **No**
Does the patient authorize Kansas City Urology Care, PA to bill the VA? ____ ____

BLACK LUNG INSURANCE INFORMATION **Yes** **No**
Are the services you are receiving today related to lung disease ____ ____

If the answer is "YES", submit claims to:

Federal Black Lung Program
PO Box 828
Lanham-Seabrook, MD 20703-0828

(**OFFICE USE ONLY** - This section must be updated or documented for each patient visit.)

Date of Service	Initial	Date of Service	Initial	Date of Service	Initial

WORKER'S COMPENSATION INSURANCE INFORMATION

Date of Accident ________________________________
Employer Name ________________________________
Employer Address ________________________________
____
Employer Phone # ________________________________
Employer Identification # ________________________________
Name of Insurance Company ________________________________
Name of Person/Company Insured ________________________________
Insurance Company Claim/Policy # ________________________________
Worker's Compensation Claim # ________________________________
Name of Worker's Compensation Agency ________________________________
Address of Worker's Compensation Agency ________________________________
____
Phone # of Worker's Compensation Agency ________________________________
Has the case been settled? Yes ____ Date ________________ No ____
Name of Patient's Legal Representative (if any) ________________________________
Phone # of Legal Representative ________________________________

(see back side)

OTHER INSURANCE INFORMATION continued
(TO BE COMPLETED IF ANY OF THE FIRST FOUR QUESTIONS ON THE M.S.P. QUESTIONNAIRE ARE ANSWERED "YES")

AUTOMOBILE, NO - FAULT OR LIABILITY INSURANCE INFORMATION

Date of Accident ______________________________

☐ If other than auto, check the box and describe the accident:

____

____

____

Name of Business / Property Owner ______________________________

Address of Business / Property Owner ______________________________

Phone # of Business / Property Owner ______________________________

Type of Insurance Premises Medical ☐ Liability ☐

Are you or a family member going to file a liability claim in connection with this injury? _______ (Y / N)

* * * * * * * *

Complete section below if an Auto, Premises Medical, or Liability Claim will be filed.

Name of Policyholder ______________________________

Address of Policyholder ______________________________

____

Phone # of Policyholder ______________________________

Policy # or Claim Identification # ______________________________

Name of Insurance Company ______________________________

Address of Insurance Company ______________________________

____

Phone # of Insurance Company ______________________________

Name of Patient's Legal Representative for this Case (if any) ______________________________

Phone # of Legal Representative ______________________________

GROUP HEALTH PLAN INFORMATION

Kansas City Urology Care, PA will take a copy of the patient's insurance card.

Insured's Name ______________________________ Relationship to Patient ______________

Employed Full Time ☐ Employed Part Time ☐

Employer Name ______________________________

Employer Address ______________________________

____

Does employer have greater than 20 employees? Yes ☐ No ☐

More than 100 employees? Yes ☐ No ☐

<u>Patient Consent to Leave Messages</u>

Kansas City Urology Care, PA, in order to comply with the privacy laws, must receive a patient authorization before leaving detailed messages (possibly containing sensitive and/or protected health information) for the patient on an answering machine, voicemail or with a live person. This practice is meant to protect the privacy of the patient and to protect the physicians and staff of Kansas City Urology Care, PA from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are authorizing Kansas City Urology Care, PA physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual, which may include sensitive and/or protected health information. You may specify what information is left and with whom by noting the information in the "Notes" section below.

I give my consent to Kansas City Urology Care, PA physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary. Check all that apply:

_____ on an answering machine or voicemail at home or cell phone

_____ on an answering machine or voicemail at work

_____ with ________________________ relationship ___________________

_____ with ________________________ relationship ___________________

_____ I do not consent to messages being left at home, work or with any other person.

Notes: ____

____

By signing below, I understand Kansas City Urology Care, PA physicians and staff will rely on the information I have provided above. Should I wish to change any of the information above (e.g., remove the name of a person authorized to receive messages about me), I understand I must contact Kansas City Urology Care, PA to update this form.

___________________________________	______________________
Patient's Name (Please Print)	**Date of Birth**
___________________________________	______________________
Patient's Signature	**Date**
___________________________________	______________________
Witness	**Date**

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Patient History Form for Use with EMR

This is a confidential record and will be kept in your electronic patient chart

Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE _______ / _______ / _______ **DATE OF BIRTH _______ / ________ / _______**

LAST NAME __________________________________ FIRST NAME ______________________________ M.I. ___

REFERRING PHYSICIAN ________________________ PRIMARY CARE PHYSICIAN ___________________________

Reason for seeing the physician on the first visit: ____

Have you been exposed to or currently have TB (tuberculosis)? Y N

Have you received the Pneumonia Vaccine in the last 9 years? Y N Date________________

ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:

____

____

LIST CURRENT MEDICATIONS *(include over the counter items such as aspirin)*

MEDICATION/DOSAGE	MEDICATION/DOSAGE
1. ____	7. ____
2. ____	8. ____
3. ____	9. ____
4. ____	10. ____
5. ____	11. ____
6. ____	12. ____

OVER-THE-COUNTER SUPPLEMENT MEDICATIONS *(if nothing marked then NONE APPLY)*

Echinacea	Metabolife	Garlic	Ginkgo	Ginseng
Kava	St. Johns Wort	Valerian	Fish Oil	Vitamin E

Other____ Other____

Are you required to take antibiotics with dental work? N Y

LAST NAME ______________________________ FIRST NAME ______________________________ DOB ________________

PAST SURGICAL HISTORY – Check previous surgeries & provide date *(if nothing marked then NONE APPLY)*

__Bladder augmentation_____________________

__Bladder suspension________________________

__Cystectomy______________________________

__Cystoscopy______________________________

__Green light PVP___________________________

__Hydrocele repair__________________________

__Kidney Stone Removal_____________________

__Laparoscopy______________________________

List type of Laparoscopy

__Lithotripsy________________________________

__Nephrectomy______________________________

__Pacemaker_________________________________

__Percutaneous nephrolithotomy_______________

__Pubovaginal sling__________________________

__Tubal ligation______________________________

__Ureteroscopy-stent_________________________

__Vasectomy_________________________________

__Adrenalectomy____________________________________

__Appendectomy____________________________________

__Back surgery______________________________________

__Breast biopsy_____________________________________

__CABG____

__Cesarean section__________________________________

__Cholecystectomy__________________________________

__Colon surgery_____________________________________

__Colonoscopy ______________________________________

__Coronary Stent____________________________________

__Gastric bypass_____________________________________

__Heart Valve Replacement___________________________

__Hernia repair______________________________________

__Hip replacement___________________________________

__Hysterectomy______________________________________

__Knee replacement__________________________________

__Mastectomy____

__Other____

PAST MEDICAL HISTORY – Check any previous past medical problems *(if nothing marked then NONE APPLY)*

___ Anemia

___ Angina

___ Arthritis

___ Asthma

___ BPH

___ Cancer__________________

List type of cancer

___ Cerebrovascular accident

___ Chronic UTIs

___ Congestive heart failure

___ COPD

___ Coronary artery disease

___ Depression

Other________________________

___ Diabetes 1 OR 2 (circle one)

___ Diverticular disease

___ GERD

___ Gout

___ Hepatitis C

___ Hypercholesterolemia

___ Hyperlipidemia

___ Hypertension

___ Hypothyroid

___ Inflammatory bowel disease

___ Liver disease

___ Lupus

Other_______________________

___ Migraine headaches

___ Multiple Sclerosis

___ Myocardial Infarction

___ Osteoarthritis

___ Osteoporosis

___ Peptic Ulcer Disease

___ Peripheral Vascular Disease

___ Renal Disease

___ Dialysis

(___Hemo ___Peritoneal)

___ Rheumatoid Arthritis

___ Seizure Disorder

___ Urolithiasis

LAST NAME ______________________________ FIRST NAME ______________________________ DOB ________________

FAMILY HISTORY

Indicate** what family member has the condition* ***(FATH, MOTH, SIS, BRO, DAU, SON)

Anesthesia Problems____ Heart Problems____ Kidney Stones____ Strokes____

Bladder Cancer____ High Blood Pressure____ Lung Problems____ Unknown History____

Bleeding Disorders____ Kidney Cancer____ Polycystic Kidneys____

Diabetes____ Kidney Disease____ Prostate Cancer____

Other Cancer (specify) ______________________________

SOCIAL HISTORY: Please Circle Answers

Marital Status: Married Single Divorced Widowed Legally Separated Annulled Life Partner Unknown

Smoking Status: (please circle and answer as appropriate)

Current Every Day Smoker? When did you start smoking?____________Packs smoked per day?___________

Current Some Day smoker? When did you start smoking?_______ Packs smoked per day? _______

Former Smoker? When did you quit? _________ Packs smoked per day? _____ How long did you smoke?____

Never Smoked Smoker, Current Status Unknown Unknown if ever smoked

Do you use Smokeless Tobacco? (please circle) Yes No

How many caffeinated drinks do you have each day? (please circle) 0 1 2 3 4+

Do you drink alcohol? (please circle) Yes, how much do you drink________ Not Anymore Never Drank

Type of alcohol consumed? **(please circle)** Beer Liquor Wine

Drinking habits? (please circle) Social Light Moderate Excessive

Do you use recreational drugs? (please circle) Yes No

Have you had a blood transfusion (please circle) Yes No

Race: (please circle) American Indian or Alaska Native Black or African American Eskimo

Native Hawaiian or Other Pacific Islander White Asian Declined to Specify Hispanic or Latino

Unknown

Language: (please circle) English Arabic Chinese Declined French German Italian

Japanese Other Portuguese Russian Spanish Vietnamese Other ______________________

Ethnicity: (please circle) Hispanic or Latino Not Hispanic or Latino Declined Unknown

Current or Former Occupation? ____

LAST NAME ______________________________ FIRST NAME ______________________________ DOB ________________

REVIEW OF SYSTEMS – **Please circle any symptoms you are currently experiencing.**

Constitutional:	Fever	Chills	Weight Loss	
Eyes:	Blurry Vision	Cataracts	Glaucoma	
Ears, Nose, Mouth, Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat	
Cardiovascular:	Chest Pains	Swollen Ankles	Irregular Heartbeat	
Respiratory:	Shortness of Breath	Wheezing	Chronic Cough	Known TB Exposure
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change in Bowels	
Genitourinary:	Incontinence	Painful Urination	Blood in Urine	Erectile Dysfunction
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles	
Integumentary/ Skin:	Rash	Persistent Itching	Skin Cancer History	
Neurological:	Numbness	Tingling	Dizziness	
Hematologic/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History	
Psychiatric:	Anxiety	Depression		

APPROXIMATE HEIGHT: ______________________________ **WEIGHT:** __________________________

Physician Signature:____ Date: ____________________________