Columbus Urology

Patient Information

_____Name

_____
Mailing Address

_____ _____ Male ( ) Female ( ) Married ( ) Single ( )
Home Phone Cell Phone

_____ _____ _____
Age Date of Birth Social Security Number

_____ _____
Primary PROVIDER Personal Email Address

EMPLOYMENT INFORMATION: (If patient is under 18 list parent/guardian's employer)

_____ _____Name
Phone

_____Address

EMERGENCY CONTACT INFORMATION:

_____ _____Name
and Relationship Phone

MEDICAL INSURANCE INFORMATION:

_____Primary
Insurance Policy Number Group

_____Policy
Holder's Name Date of Birth Social Security #

_____Secondary
Insurance Policy Number Group

_____
Policy Holder's Name Date of Birth Social Security #

***FOR PATIENTS UNDER THE AGE OF 18, PLEASE LIST:**

_____ _____ _____
Parent/Guardian(s) Name Date of Birth Social Security Number

Patient's Name: _____

Height: _____ Weight:_____

Patient's Medical History: Circle any that apply)

Diabetes
Cancer
Arthritis
Ulcer
Renal Failure
Stones
Recurrent Urinary Tract Infections
Recurrent Prostate Infections
Stroke
Asthma
COPD
Blood Clot
Pulmonary Embolism
Heart Attack
Congestive Heart Failure
Arrhythmia
High Blood Pressure
Diverticulitis
Depression
Hepatitis
Anemia
Thyroid Disease
Other _____

FAMILY Medical History: (DO NOT INCLUDE YOURSELF)

Cancer If so, what type of cancer: _____?
Prostate Cancer
Kidney Stones
Heart Disease
Diabetes
Stroke
High Blood Pressure

Please list surgeries that you have had in the past:

_____
_____
_____

Social History: Circle any that apply

Single Married Divorced Widowed

Smoker Y or N
How many daily?
Former Smoker Y or N

Drink Alcohol Y or N
Illicit Drug Use Y or N

Coffee Y or N
How many cups daily?
Sodas/Tea Y or N
How much daily?

Please list any Drug Allergies:_____

_____

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KEVIN BOND, MD, PAUL BARRETT CFNP, KIMBERLY ROBERTSON, FNP-C

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your records to anyone unless you direct us to do so or unless the law authorizes us to do so. Our notice of patient privacy describes in detail how your health information may be used and how you can access your information.

PURPOSE: To provide patient care
INFORMATION TO BE DISCLOSED: All Urology Group medical information/records including labs and other referred services.
PERSONS AUTHORIZED TO USE OR DISCLOSE: The staff of Urology Group.
EXPIRATION: Indefinite unless revoked or terminated by the patient or patient's representative.
RIGHT TO TERMINATE: You may revoke or terminate this disclosure by submitting a written revocation to the front office of Urology Group.

PERSONS TO WHO MY MEDICAL INFORMATION MAY BE DISCLOSED TO:

Person's Name & Relationship/Organization:_____

Person's Name & Relationship/Organization: _____

Person's Name & Relationship/Organization:_____

Person's Name & Relationship/Organization: _____

BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES AND PERMISSION TO DISCLOSE MY MEDICAL INFORMATION TO THE ABOVE-MENTIONED PARTIES.

_____ _____

Name of Patient Patient's Signature or Legal Representative

_____

Date

Please complete all pages prior to your appointment. Be sure to bring the new patient paperwork, your insurance cards, driver's license or photo I.D., and the medications that you are currently taking to your appointment (please do not mail information to us). If you have any questions, please call the number above.

We look forward to seeing you on _____at _____.

Columbus Office

321 Hospital Drive

Columbus, MS 39705

Phone: 662-327-2921

Fax: 662-328-6858