

PATIENT INFORMATION

1. PATIENT NAME _____
Title (Mr/Mrs/MS) First Name Middle Init. Last Name
2. NAME WE SHOULD CALL YOU _____
3. PATIENT STREET ADDRESS _____
4. CITY _____ 5. STATE _____ 6. ZIP _____
7. HOME PHONE (____) _____ 8. WORK PHONE (____) _____
9. BIRTH DATE _____ 10. AGE _____ 11. SEX _____ 12. MARITAL STATUS _____
Monthr Day Year M/F (S/M/D/W)
13. PHYSICIAN OR PERSON WHO REFERRED YOU _____
14. PATIENT EMPLOYER _____ 15. OCCUPATION _____
16. EMPLOYER ADDRESS _____
17. S.S. NUMBER _____ - _____ - _____ 18. STUDENT? _____ AT _____
Yes/No SCHOOL OR UNIVERSITY
19. EMERGENCY CONTACT _____ PHONE (____) _____ RELATIONSHIP _____
Name of Person
20. FAMILY OR PRIMARY CARE PHYSICIAN _____

GUARANTOR INFORMATION
 (FINANCIALLY RESPONSIBLE PARTY)

Note: Skip this section if GUARANTOR is the same person as PATIENT above.

1. GUARANTOR NAME _____
2. GUARANTOR STREET ADDRESS _____
3. CITY _____ 4. STATE _____ 5. ZIP _____
6. HOME PHONE (____) _____ 7. WORK PHONE (____) _____
7. GUARANTOR EMPLOYER _____ 9. OCCUPATION _____
10. EMPLOYER ADDRESS _____
Street City State Zip
11. GUARANTOR S.S. NUMBER _____ - _____ - _____ 12. DATE OF BIRTH _____
13. SPOUSE'S NAME _____ 14. SPOUSE'S WORK PH. (____) _____

INSURANCE INFORMATION

Note: Skip this section if we have photocopied your insurance card.

1. PRIMARY INSURANCE CO. _____
2. POLICY HOLDERS RELATION TO PATIENT: SELF _____ GUARANTOR _____ OTHER _____
3. INSURANCE CO. ADDRESS _____
Street City State Zip
4. SUBSCRIBER NO. _____ 5. GROUP NO. _____
6. SECONDARY INSURANCE CO. _____
7. POLICY HOLDER'S RELATIONSHIP TO PATIENT: SELF _____ GUARANTOR _____ OTHER _____
8. INSURANCE CO. ADDRESS _____
Street City State Zip
9. SUBSCRIBER NO. _____ 10. GROUP NO. _____

MEDICAL INFORMATION

Please feel free to ask for assistance.

NAME _____ AGE _____

BRIEFLY STATE YOUR UROLOGICAL PROBLEM OR REASON FOR VISITING THE DOCTOR TODAY _____

TELL US ABOUT YOUR PAST MEDICAL HISTORY. Please include all serious illnesses or conditions including: diabetes, thyroid problems, heart disease, blood clots, transfusion problems, high blood pressure, stroke, tuberculosis, stomach or bowel disease, kidney, bladder or prostate disease, broken bones or joint disease, arthritis, cancer, muscle disorders, mental health problems or mental disabilities, or any other medical condition we should know about.

PLEASE LIST ALL SURGERIES AND APPROXIMATE YEAR: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____ IF YES, PLEASE LIST: _____

PLEASE LIST ALL MEDICATIONS YOU NOW TAKE ALONG WITH DOSE AND HOW OFTEN YOU TAKE IT.

Please include prescriptions, eyedrops, over-the-counter medications, aspirin, ibuprofen, and diet aids.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING:

____ Diabetes ____ Cancer ____ Heart Disease

Do you smoke or chew tobacco? No _____ Yes _____ How many packs per day: _____ For how many years: _____
Do you drink alcohol? No _____ Light _____ Medium _____ Heavy _____
Do you use any "recreational" drugs
or have you shared needles? No _____ Light _____ Medium _____ Heavy _____

DO YOU HAVE ANY OF THE FOLLOWING GENERAL MEDICAL PROBLEMS? (Please check (✓) all that apply.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Recent fever | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Prolonged episodes of diarrhea |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Constipation problems |
| <input type="checkbox"/> Weight loss not associated with diet | <input type="checkbox"/> Recent voice change | <input type="checkbox"/> Change in color of stool |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Non-healing sore in mouth | <input type="checkbox"/> Blood in stool or tar-colored s |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Recent changes in vision | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Blurring of visual fields | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Weakness in the arms or legs |
| <input type="checkbox"/> Pain in the eyes | <input type="checkbox"/> Breast lump or redness | <input type="checkbox"/> Loss of feeling in hands or feet |
| <input type="checkbox"/> Excess tearing or discharge from eyes | <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Seizures or epilepsy |
| <input type="checkbox"/> Changes in hearing | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> A sore that won't heal |
| <input type="checkbox"/> Recent ear infection | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Persistent rash, hives, or eczema |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Heart attack | <input type="checkbox"/> A change in a wart or a mole |
| <input type="checkbox"/> Ear pain or discharge from ears | <input type="checkbox"/> Rheumatic fever as child | <input type="checkbox"/> Easy bruising or bleeding |
| <input type="checkbox"/> Frequent bloody nose | <input type="checkbox"/> Poor circulation in legs | <input type="checkbox"/> Dizziness, fainting or vertigo |
| <input type="checkbox"/> Excess nasal secretions | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Loss of taste or smell | <input type="checkbox"/> Prolonged nausea or vomiting | <input type="checkbox"/> Other psychiatric problems |
| <input type="checkbox"/> Other problems you think we should know about (please specify) _____ | | |

DO YOU HAVE ANY OF THE FOLLOWING UROLOGICAL PROBLEMS? (Please check (✓) or give number where applicable)

- | | | |
|---|--|--|
| <input type="checkbox"/> Pain or burning with urination | <input type="checkbox"/> Blood in the urine | <input type="checkbox"/> Urinary urgency |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Sores or rash on genitals |
| <input type="checkbox"/> History of Venereal disease | <input type="checkbox"/> Number of times you typically arise at night to void? | |

FOR MEN ONLY: (Please check (✓) or give number where applicable)

- | | | |
|---|---|---|
| <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Dribbling or weak stream | <input type="checkbox"/> Difficulty starting stream |
| <input type="checkbox"/> Feeling of incomplete emptying | <input type="checkbox"/> Straining to void | <input type="checkbox"/> Incontinence of urine |

FOR WOMEN ONLY: (Please check (✓) or give number where applicable)

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent urinary tract infections | <input type="checkbox"/> Number of pregnancies | <input type="checkbox"/> Number of deliveries |
| <input type="checkbox"/> Frequent voids during the day | <input type="checkbox"/> Incontinence of urine and → → | <input type="checkbox"/> Number of pads used per day |

Other UROLOGICAL problems you think we should know about (please specify) _____

PLEASE LEAVE THE SPACE BELOW FOR DOCTOR'S NOTES

Logan Urology Clinic

OFFICE POLICY ON PAYMENT

We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

1. Payment for services is the responsibility of the patient or guarantor and is expected at the time of service unless other arrangements have been made.
2. Your insurance is a contract between you and your insurance company. While we are happy to file insurance claims on your behalf, charges for our services are your responsibility from the date the services are rendered.
3. Our office will usually obtain pre-authorization from your insurance company prior to any covered procedure. Pre-authorization, however, does not guarantee payment. This office cannot be responsible for negotiating a settlement on a disputed claim with your insurance company.
4. Balances older than 30 days will be assessed finance charges at 1% per month, with a minimum charge of \$.50 per month. Statements will be mailed every 30 days to update you on the progress of your claims. There is a \$10 service charge for all returned checks.

I understand, (regardless of my insurance status), that in the event of default of the above policies, I agree to pay all collection costs, including, but not limited to reasonable attorney's fees, court costs, costs of preparing documents for court and collection agency costs, whether incurred by filing a lawsuit or otherwise.

I authorize the release of any information, including medical and billing information, by the office of Drs. Larsen and Callister to my insurance company (ies). I request that payment or rejection notice be sent directly to the physicians.

Signature of Responsible Party

Date