MRN: ***«PNumber»*** | Patient Name*: «Pname»*			Date of Birth*: «Pdob»*
Address*: «Pstreet1»*	City*: «Pcity»*	State: ***«Pstate»***	Zip*: «Pzipcode»*
Home Phone*: «Phtele»*	Cell Phone*: «Pctele»*		Sex*: «Psex»*
Race*: «Additfield1»*	Ethnicity*: «Additfield2»*	Language*: «Additfield3»*	

PATIENT INFORMATION

Social Security #: _____-_____-_____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Sex: □ Male □ Female DOB: _____ Email: _____

Referring Doctor: _____ PCP: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

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IF PATIENTS INSURANCE IS NOT THROUGH EMPLOYER OR PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION.

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

Sex: □ Male □ Female Date of Birth : _____/_____/_____ Social Security #: _____-_____-_____

Responsible Party Employer: _____

Relationship to Patient: _____

MEANINGFUL USE DATA

Race: □ African American □ Asian □ Caucasian □ Hispanic □ Indian □ Native American □ Pacific Islander

Ethnicity: □ Hispanic □ Non-Hispanic Preferred Language: □ English □ Spanish □ Other: _____

IN CASE OF EMERGENCY

Relative/Friend: _____ Relationship: _____

Home #: (_____)_____-_____ Work #: (_____)_____-_____ Cell #: (_____)_____-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Middle Tennessee Urology Specialist or my insurance company to release any information required to process my claims.

PATIENT SIGNATURE: _____ DATE: _____

MRN: ***«PNumber»*** | Patient Name*: **«Pname»***	Date of Birth*: **«Pdob»***

Financial Agreement

For services rendered to the patient named below, I, the undersigned, agree to pay all professional and/or outpatient charges not covered by insurance. This includes any co-payments, co-insurance and deductibles that may be owed. **I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.**

_____ _____

Patient and /or Guardian Signature Date

Authorization to Release Medical Information and payment of Insurance Benefits

I hereby authorize Middle Tennessee Urology Specialist or my attending physician to release or disclose to insurance companies and/or outpatient benefits programs information from my medical record pertaining to my treatment as needed to process insurance claims. Furthermore, I hereby assign payment directly to Middle Tennessee Urology Specialist benefits wherein specified and otherwise payable to me but not to exceed Middle Tennessee Urology Specialist regular charges for medical treatment. I understand that I am financially responsible for charges not covered by this authorization.

_____ _____

Patient and /or Guardian Signature Date

Statement to Permit Payment of Medicare Benefits to Physician (Medicare Patients Only)

I certify that the information given by me in applying for payments under the Title XVII of the Social Security Administration or it intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payment for physician services to the physician or organization furnishing the services, and authorize such physician or organization to submit claims to Medicare for payment.

_____ _____

Patient and /or Guardian Signature Date

Prescription Refills

Telephone prescription refills must be requested on Monday – Friday between the hours of 8:30 am and 4:00 pm. Please allow 24 – 48 hours for your prescription to be called in. Telephone prescription refills may be delayed due to necessity for the physician to review your record and determine the appropriate medicine to prescribe. Also, please note that it is our belief that narcotic pain relievers are, in general, for short-term use only. Likewise, prescriptions **will not** be called in after hours and on weekends.

_____ _____

Patient and /or Guardian Signature Date

Return Phone Calls

The clinic staff at Middle Tennessee Urology Specialist will return patient phone calls received before 4:30 pm Monday through Friday before the clinic closes that day. Calls after this time will be returned the next business day. If you believe your medical situation is urgent in nature, please proceed to a hospital emergency room for immediate treatment.

_____ _____

Patient and /or Guardian Signature Date

MiddleTennessee Urology specialists

ACKNOWLEDGEMENT FORM

MRN: «PNumber»

ROBERT CLEVELAND, M.D. (RETIRED) ◆ **ROBERT DRAY, M.D.** ◆ **CHAD JACKSON, M.D.**
THEODORE SHEPARD, M.D. ◆ **PATRICK SHOWALTER, M.D.** ◆ **GREGORY STEWART, M.D.**

PATIENT NAME: «PNAME»

DOB: «PDOB» **SSN: «PSSN»**

ADDRESS: «PSTREET1»

CITY: «PCITY» **ZIP: «PZIPCODE»**

HOME PHONE: «PHTELE» **CELL PHONE: «PCTELE»** **WORK PHONE: «PWTELE»**

EMAIL: _____

MAY WE LEAVE A MESSAGE AT ANY OR ALL OF THESE NUMBERS? YES OR NO

IF YES, WHICH NUMBERS: HOME WORK CELL OR ALL

PLEASE LIST ANY FAMILY MEMBER OR CARE GIVER THAT YOU WOULD LIKE FOR US TO PROVIDE INFORMATION ABOUT YOUR MEDICAL CARE TO IF ANY. (ANYONE YOU MAY HAVE US CALL FOR YOU TO CANCEL YOUR APPOINTMENT, OBTAIN TEST RESULTS, OR RESCHEDULE PROCEDURES MUST BE LISTED BELOW.)

1. _____ PHONE (____) _____-_____ RELATIONSHIP: _____
2. _____ PHONE (____) _____-_____ RELATIONSHIP: _____
3. _____ PHONE (____) _____-_____ RELATIONSHIP: _____

I ACKNOWLEDGE RECEIPT OF THE PRIVACY NOTICE WHICH DESCRIBES HOW MY PROTECTED HEALTH INFORMATION WILL BE USED AND DISCLOSED AND HOW I CAN ACCESS THIS INFORMATION.

PATIENT'S SIGNATURE: _____ DATE: _____

Patient Name: «PName» **DOB**: «PDOB» **Date:** _____

Who referred you to this office? «RFName» **Medical Doctor/PCP:** «PCPName»

When did your problem start: _____ **Pharmacy (Name & Number):**_____

I AM HERE TODAY FOR: (PLEASE CIRCLE ALL THAT APPLY)

BLADDER: ☐ CANCER ☐ INFECTION ☐ OVERACTIVE ☐ PAIN ☐ DROPPED BLADDER (FEMALE)

URINARY: ☐ BLOOD IN URINE ☐ INCONTINENCE ☐ INTERSTITAL CYSTITIS ☐ LEAKAGE

KIDNEY: ☐ STONES

PROSTATE (Males Only): ☐ CANCER ☐ ENLARGED ☐ HIGH PSA ☐ INFECTION ☐ LUMP IN TESTICLE ☐ INFERTILITY ☐ ERECTILE DYSFUNCTION

ALLERGIES (PLEASE CHECK ALL THAT APPLY)

☐ NONE ☐ PCN ☐ SULFA ☐ CIPRO ☐ IODINE /CONTRAST OTHER: _____

CURRENT MEDICATIONS *PLEASE LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS OR PROVIDE LIST*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

SURGICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ APPENDECTOMY ☐ BACK/HIP/KNEE ☐ CYSTOSCOPY ☐ GALLBLADDER ☐ HEART BYPASS

☐ KIDNEY STONE SX ☐ LITHOTRIPSY ☐ COLONOSCOPY ☐ DIAGNOSTIC SIGMOIDOSCOPY

FEMALES ONLY: ☐ BLADDER TACK ☐ HYSTERECTOMY ☐ SLING (TVT) DELIVERIES: _____ C-SECTION_____

MALES ONLY: ☐ PROSTATE BIOPSY ☐ PROSTATE SEED ☐ PROSTATE SURGERY

HAVE YOU EVER HAD THE PNEUMOCOCCAL VACCINE? (G8864) ☐ YES ☐ NO

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ DIABETES ☐ EMPHYSEMA ☐ HEART ATTACK ☐ HEART MURMUR ☐ HEART DISEASE ☐ HEPATITIS

☐ HERNIA ☐ HYPERTENSION ☐ PARKINSON'S ☐ STROKES ☐ MENOPAUSE LAST PERIOD: _____

CANCER: ☐ PROSTATE ☐ KIDNEY ☐ TESTIS OTHER: _____

FAMILY HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ HEART DISEASE ☐ KIDNEY CANCER ☐ KIDNEY STONES ☐ PROSTATE CANCER

SOCIAL HISTORY(PLEASE CHECK ALL THAT APPLY)

DO YOU SMOKE? ☐ YES ☐ NO HOW MANY CAFFEINATED DRINKS DAILY? 0 1 2 3 4+

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

IF YES, DRINKING HABITS ARE: ☐ SOCIAL ☐ LIGHT ☐ MODERATE ☐ EXCESSIVE OCCUPATION:

MY SYMPTOMS ARE:

GENERAL/CONSTITUTIONAL	☐ FEVER	☐ WEIGHT LOSS	☐ CHILLS
EYES	☐ BLURRY VISION	☐ DOUBLE VISION	☐ CATARACTS
EARS, NOSE, MOUTH, THROAT	☐ HEARING LOSS	☐ NASAL STUFFINESS	☐ SORE THROAT
CARDIOVASCULAR	☐ CHEST PAINS	☐ SWOLLEN ANKLES	☐ IRREGULAR HEARTBEAT
RESPIRATORY	☐ SHORTNESS OF BREATH	☐ WHEEZING	☐ CHRONIC COUGH
GASTROINTESTINAL	☐ ABDOMINAL PAIN	☐ NAUSEA/VOMITING	☐ CHANGE IN BOWELS
GENITOURINARY	☐ INCONTINENCE	☐ PAINFUL URINATION	☐ BLOOD IN URINE
MUSCULOSKELETAL	☐ CHRONIC BACK PAIN	☐ CHRONIC NECK PAIN	☐ SORE MUSCLES
INTEGUMENTARY/SKIN	☐ RASH	☐ PERSISTENT ITCHING	☐ SKIN CANCER HISTORY
NEUROLOGIC	☐ NUMBNESS	☐ TINGLING	☐ DIZZINESS
HEMATOLOGIC/LYMPHATIC	☐ SWOLLEN GLANDS	☐ ABNORMAL BLEEDING	☐ TRANSFUSION HISTORY

MY URINARY SYMPTOMS ARE:

☐ FREQUENCY ☐ URGENCY ☐ LEAKAGE ☐ STRAINING ☐ ABDOMINAL PAIN

☐ BLADDER PAIN ☐ STRAINING ☐ WEAK STREAM ☐ INTERMITTENCY ☐ TESTICLE PAIN

☐ PAIN IN SIDE R / L ☐ INCOMPLETE EMPTYING ☐ URINATING AT NIGHT #_____