



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

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: « <i>PNumber</i> » Patient Name: « <i>Pname</i> »	Date of Birth: « <i>Pdob</i> »
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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
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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
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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 its 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
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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
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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
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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 INTERSTITIAL 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 | <input type="checkbox"/> FEVER | <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> CHILLS |
| EYES | <input type="checkbox"/> BLURRY VISION | <input type="checkbox"/> DOUBLE VISION | <input type="checkbox"/> CATARACTS |
| EARS, NOSE, MOUTH, THROAT | <input type="checkbox"/> HEARING LOSS | <input type="checkbox"/> NASAL STUFFINESS | <input type="checkbox"/> SORE THROAT |
| CARDIOVASCULAR | <input type="checkbox"/> CHEST PAINS | <input type="checkbox"/> SWOLLEN ANKLES | <input type="checkbox"/> IRREGULAR HEARTBEAT |
| RESPIRATORY | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> WHEEZING | <input type="checkbox"/> CHRONIC COUGH |
| GASTROINTESTINAL | <input type="checkbox"/> ABDOMINAL PAIN | <input type="checkbox"/> NAUSEA/VOMITING | <input type="checkbox"/> CHANGE IN BOWELS |
| GENITOURINARY | <input type="checkbox"/> INCONTINENCE | <input type="checkbox"/> PAINFUL URINATION | <input type="checkbox"/> BLOOD IN URINE |
| MUSCULOSKELETAL | <input type="checkbox"/> CHRONIC BACK PAIN | <input type="checkbox"/> CHRONIC NECK PAIN | <input type="checkbox"/> SORE MUSCLES |
| INTEGUMENTARY/SKIN | <input type="checkbox"/> RASH | <input type="checkbox"/> PERSISTENT ITCHING | <input type="checkbox"/> SKIN CANCER HISTORY |
| NEUROLOGIC | <input type="checkbox"/> NUMBNESS | <input type="checkbox"/> TINGLING | <input type="checkbox"/> DIZZINESS |
| HEMATOLOGIC/LYMPHATIC | <input type="checkbox"/> SWOLLEN GLANDS | <input type="checkbox"/> ABNORMAL BLEEDING | <input type="checkbox"/> 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 # _____