

Landmark Urology

Patient Information: (Please Print)

Today's Date: ___/___/___

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Can we leave a message? Y N

Date of Birth: ___/___/___ Age: _____ Sex: _____ Marital Status: _____

Email Address: _____

Which method is best to contact you? (circle one) Home Phone Cell Phone Work Phone Email

Emergency Contact Name: _____ Relationship: _____ Phone#: _____

Employment Status: Employed Retired Unemployed

What is your occupation? _____ Employer: _____

Employer Address: _____

Work Phone: _____ extension _____ Can we leave a message? Y N

Parent/Responsible Party (If different from patient)

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Insurance Information/Policy Holder

Do you have insurance? Y N

Primary Insurance: _____ ID# _____ Group#: _____

Secondary Insurance: _____ ID# _____ Group#: _____

Name of Card(s) Holder: _____ DOB: ___/___/___

SS#: _____

Other Information:

Referred by: _____ Primary Care Physician: _____

Pharmacy of Choice: _____ City: _____ State: _____

Pharmacy phone number () _____

Name: _____ Date: _____

Referring Doctor: _____ Family Doctor: _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

What improves or worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous or does it come and go? _____

Describe the pain (sharp/dull, etc.) _____

Have you tried any medicine/treatment for this problem/pain? _____

CURRENT MEDICATIONS - Please list ALL medications you are currently taking including over the counter meds

Drug Name:	Strength:	Directons/How you take it:
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-----	-----	-----
-----	-----	-----

Attach list if necessary

Pharmacy Name: _____ Phone #: _____

ALLERGIES - Please list ALL types (Drug, seasonal, pets, environmental foods)

By what method did you choose our practice:

____ Referring Physician ____ Friend ____ Yellow Pages ____ Insurance Company ____ Other

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years

____ Single ____ Married ____ Separated ____ Divorced ____ Widowed ____ Life Partner ____ Common Law Spouse

Dependants: Please indicate # of each, if you have:

____ Sons ____ Daughters ____ Stepchildren ____ Adopted ____ Foster ____ Parents ____ Grandparents

Occupation: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other

Hobbies: Please circle any that apply to you:

None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

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Alcohol Consumption:

___None ___Yes Occasional/Social # of drinks per day ___

Tobacco per day:

___None ___Yes # ___Packs/day ___Cigarettes/day ___Smokeless Tobacco

If you previously stopped, When? _____

Recreational Drugs: ___None If yes, please list: _____

Caffeinated beverages: None Low Moderate Excessive

Recent Foreign Travel: None Americas _____ Worldwide _____

REVIEW OF SYSTEMS:

Constitutional

Appetite Changes
Anorexia
Aches and Pains
Chills
Easy Bruising
Fever
Fatigue
Generalized Weakness
Insomnia
Night Sweats
Sleep Apnea
Swollen Glands
Weight Gain
Weight Loss

Eyes

Blind
Blurred Vision
Double Vision
Glaucoma
Pain
Worsening Eyesight

Allergic/Immunologic

Animal Allergies
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

Neurological

Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems

Tremors

Endocrine

Diabetes
Excessive thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too Hot/Cold

Gastrointestinal

Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/heartburn
Irregular Bowel Movements
Nausea/vomiting
Rectal Bleeding
Tarry Stool

Cardiovascular

Chest Pain/Angina
Dyspnea on Exertion
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse
Orthopnea
Pain/Cramps Hips/Legs w/exercise
Palpitation

Skipped Heart Beats
Swelling

Skin

Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin rash

Musculoskeletal

Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness

Ear/Nose/Throat

Ear Infection
Sinus Problem
Sore Throat

Genitourinary

Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Enuresis
Not Emptying

Painful Ejaculation
Stranguria
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream

Respiratory

Asthma
Emphysema-Bronchitis
Environmental Allergies
Frequent Cough
Pneumonia
Shortness of breath
Tuberculosis
Wheezing

Hematological/Lymphatic

Swollen Glands
Blood clotting problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell

Psychologic

Anxiety
Depressed
Generally satisfied with life

Other: _____

Name: _____

Date: _____

PAST MEDICAL HISTORY

Please **CIRCLE** if you **have** or **have had** any of the following diseases or conditions:

Cardiovascular

- Anemia
- Angina
- Anorexia
- Aortic Aneurysm
- Aortic Regurgitation
- Aortic Stenosis
- Arrhythmia
- Atrial Fibrillation
- Bleeding Disorder
- Cardiomyopathy
- Cerebrovascular Disease
- Claudication
- Congenital Heart Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Deep Vein Thrombosis
- Endocarditis
- Enlarged Heart
- Heart Attack
- Heart Block
- Heart Disease
- Heart Murmur
- Heart Valve Problem
- Hemophilia
- Hypertension, well controlled
- Hypertension, progressive
- Hypertension, severe
- Leukemia
- Mitral Insufficiency
- Mitral Stenosis
- Mitral Valve Prolapse
- Rheumatic Fever
- Sickle Cell Anemia
- Stroke
- Thrombophlebitis
- Varicose Veins
- Ventricular Arrhythmia

Endocrine/Metabolic

- Diabetes Mellitus, non-insulin dependent
- Diabetes Mellitus, insulin dependent
- Diabetes Mellitus, uncontrolled
- Goiter
- Gout
- Hyperthyroidism
- Hypothyroidism
- Impaired Glucose Tolerance

General

- Allergies
- Electrical Injury
- Exposure to Chemicals
- Hepatitis A

- Hepatitis B
- Hepatitis C
- Hypercholesterolemia
- Hyperlipidemia
- Infectious Disease
- Lipid Disorder
- Malaise
- Obesity
- Paget's Disease
- PCKD
- PCO
- Raynaud's Syndrome
- Sleep Apnea

GI

- Cholecystitis
- Cholelithiasis
- Chronic Liver Disease
- Colitis
- Constipation
- Colon Condition
- Crohn's Disease
- Diarrhea
- Diverticulitis
- Diverticulosis
- GERD
- Hemorrhoids
- Hepatic Failure
- Hepatitis
- Hiatal Hernia
- Inflammatory Bowel Disease
- Liver Disease
- Pancreatitis
- Peptic Ulcer (Duodenal)
- Rectal Fissure
- Stomach Ulcer
- Ulcerative Colitis

GU

- AIDS
- Bladder Outlet Obstruction
- Bladder Stone
- Bladder Infection
- Chronic Renal Disease
- Chronic Renal Insufficiency
- Chronic Renal Failure
- Crossed Fused Ectopia
- Hematuria
- Impotence of Organic Origin
- Interstitial Cystitis
- Irradiation Therapy
- Kidney Cancer
- Kidney Disease
- Kidney Infection
- Kidney Stones
- Libido Decreased

- Nephrolithiasis
- Nephrotic Syndrome
- Neurogenic Bladder
- Orchitis
- Penile Discharge
- Polycystic Disease
- Polycystic Kidney Disease
- Prostate Cancer
- Radiation or Nuclear Exposure
- Recurrent UTI
- Renal Cell Cancer
- Renal Failure
- Renal Insufficiency
- Testicular Cancer
- Transplant Recipient
- Transitional Cell CA Bladder
- Transitional Cell CA Ureter
- Undescended Testicle (Birth)
- Urinary Tract Infection
- Venereal Disease

GYN/OB

- Breast Cancer
- Breast Disease
- Endometriosis
- Menopause
- Menstrual Problems
- Osteoporosis
- Ovarian Cancer
- Uterine Fibroids

HEENT

- Blindness
- Cataracts
- Deviated Septum
- Deafness
- Ear Infections
- Glaucoma
- Hay Fever
- Menniere's
- Mumps
- Sinusitis
- Tinnitus
- Vertigo

Musculoskeletal

- Arthritis
- Back Pain
- Carpal Tunnel Syndrome
- Claudication
- Fibromyalgia
- Mortons Neuroma

Neurological/Psychological

- ADD
- ADHD

- Alcoholism
- Alzheimer's Disease
- Anxiety
- Bi-polar Disorder
- Chronic Fatigue Syndrome
- Depression
- Eating Disorder
- Epilepsy
- Herniated Disc
- Mental Illness
- Migraine
- Multiple Sclerosis
- Nervous Breakdown
- Organic Brain Syndrome
- Parkinson's
- Polio
- Seizures
- Spinal Cord Injury
- Stroke
- Suicide Attempt

Respiratory

- Asthma
- Bronchitis
- Chronic Lung Disease
- COPD
- Emphysema
- Lung Disease
- Pneumonia
- Pulmonary Embolism
- Tuberculosis

Tumors

- Brain Cell Carcinoma
- Brain Tumor
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Fibrocystic Breast Disease
- Gastric Cancer
- Laryngeal Cancer
- Lung Cancer
- Lymphoma
- Melanoma
- Ovarian Cancer
- Pancreatic Cancer
- Rectal Cancer
- Rectal Cancer
- Rectal Cell Cancer
- Sarcoidosis
- Testicular Cancer
- Transitional Cell CA Bladder
- Transitional Cell CA Ureter
- Uterine CA

Other: _____

SURGICAL HISTORY

Please **CIRCLE** if you **have had** any of the following surgeries and date of surgery:

Cadiovascular

Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery
Heart Surgery (Stents)
Heart Transplant
Pacemaker Insertion
Vein Stripping

General

Brain Surgery
C-section
Laminectomy
Lymphatic Node
Dissection
Hysterectomy
Parathyroidectomy
Pilonidal Cyst Incision
Skin Grafting

GI

Appendectomy
Bariatric Surgery
Bowel Resection
Cholecystectomy
Colon Resection
EGD
EGD/Dilation Esophagus
Fissurectomy
Gall Bladder surgery
Gastric Surgery

Hemorrhoidectomy
Ileostomy
Laparoscopy
Liver Surgery
Liver Transplant
Lumpectomy of Breast
Lysis Adhesions
Nissen Fundoplication
Splenectomy
Stomach Surgery
Umbilical Hernia
Ventral Hernia Repair

GU

Bladder Surgery
Biopsy Prostate
Brachytherapy
Circumcision
Contigen
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy-Stent
Cysto-TUR Fulguration
Durasphere
Epididymectomy
ESWL
Herniorrhaphy
Hydrocelectomy
Ileal conduit
Indigo Laser Surgery
Inguinal Herniorrhaphy
Interstim

Kidney Stone
Laser Lithotripsy
Meatotomy
Needle Biopsy Prostate
Nephrectomy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Implant
Penectomy
Penile Surgery
Pyeloplasty
Radical Prostatectomy
Renal Transplant
Spermatocectomy
TUMT Prostate
TUNA Prostate
TURBT
TUR Prostate
Ureteroscopy
Variocelectomy
Vasectomy
VLAP

HEENT

Cataract Surgery
Corneal Surgery
Ear Surgery
Eye Surgery
Facial Surgery
Mastoid Surgery
Nasal Surgery
PEG

PE Tubes
Septoplasty
Sinus Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery

Musculoskeletal

Amputation
Arthroscopic Knee
Surgery
Back Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Hip Surgery
Knee Surgery
Leg Surgery
Rotator Cuff Surgery
Shoulder Surgery

Respiratory

Lung Surgery

Skin

Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

Other: _____

FAMILY HISTORY

Please **CIRCLE** and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt)

Arthritis _____
Bedwetting _____
Bladder Cancer _____
Cancer (site unknown) _____
Crohn's Disease _____
Depression _____
Diabetes _____
Gout _____
Heart Attack _____
Hypertension _____
Kidney Disease _____

Leukemia _____
Malignant Melanoma _____
Multiple Sclerosis _____
Laryngeal Cancer _____
Pancreatic Cancer _____
Prostate Cancer _____
Stroke _____
Thyroid Disease _____
Tuberculosis _____

Other: _____

Landmark Urology

Authorization:

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. All co-pays are payable at time of service.

I hereby authorize Landmark Urology, PSC, to furnish insurance companies or their representatives information concerning my (or my dependents) illness and treatments and I hereby assign to Landmark Urology, PSC, all payments for medical services rendered by myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Appointment Policy:

If you cannot make your appointment, please give us at least 24 hours notice. We reserve the right to impose a \$25.00 missed appointment fee. Excessive no shows could result in dismissal.

Patient or Responsible Party

Date

HIPPA Acknowledgement:

I have received the notice of privacy practices from Landmark Urology, PSC.

Patient or Authorized Representative: _____ Date: _____

I consent to treatment by Amberly K. Windisch, M.D. including but not limited to radiology and lab testing. I authorize the release of my records to my insurance company (including HCFA and its agents) for claims payment purposes. I authorize payment of Medical/Medicare benefits to Amberly K. Windisch, M.D. for services rendered and I understand that I am ultimately responsible for payment. I certify that the information provided at this time is accurate.

Patient of Responsible Party Signature

Date Signed

Assignment of Benefits:

I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled. This includes Medicare, private insurance, and other health plans to Landmark Urology, PSC. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the release of all my medical records from other physicians and institutions in order that I may be given the appropriate care.

Patient of Responsible Party Signature

Date Signed

Landmark Urology

Authorization to Release Information:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid services (CMS, formerly HCFA) or its intermediaries or carriers any information need for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original signed assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (section 1128 B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). We will file all claims as a courtesy to you and your insurance company (s) and all necessary documentation for claim processing.

Patient of Responsible Party Signature

Date Signed

Patient Financial Responsibility:

If your insurance company has not paid your claim after 90 days, the full amount of the bill is your responsibility and payment is due immediately. Furthermore, I understand that, if for any reason, the account is turned over to a collection agency, I will be responsible for the collection of fee of 35% and should non-payment of your account result in litigation, the collection fee shall increase to 50%, and I will also be responsible for court cost and service of summons cost.

Patient or Responsible Party Signature

Date Signed