

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: _____

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

Employment Status: __Employed __Retired __Unemployed__
Occupation: _____
Employer: _____

Employer

Address: _____

Work Phone: _____

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: _____

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?

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

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?

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
Meniere'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
Spermatoclectomy
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

Landmark Urology

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:

FAMILY HISTORY

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

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

Arthritis _____

Leukemia _____

Bedwetting _____

Malignant Melanoma _____

Bladder Cancer _____

Multiple Sclerosis _____

Cancer (site unknown) _____

Laryngeal Cancer _____

Crohn's Disease _____

Pancreatic Cancer _____

Depression _____

Prostate Cancer _____

Diabetes _____

Stroke _____

Gout _____

Thyroid Disease _____

Heart Attack _____

Tuberculosis _____

Hypertension _____

Kidney Disease _____

Other:

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 or Responsible Party

Date

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 or Responsible Party

Date

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 or Responsible Party

Date

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

Date
