Premier Urology Corp.

477 Cooper Road, Suite 220
Westerville, OH 43081
614-818-0215

Your appointment with: Dr. David H. Brown

Dr. Jed W. Henry

Dr. Adam J. Clemens

is scheduled for _____.

Welcome to our practice. It is our desire to make your visit to our office as smooth and efficient as possible. We thank you in advance for your cooperation.

- As a courtesy to you, we are sending you these forms to be completed **before** your arrival for your visit. We are transitioning to electronic medical records, and all information in your medical record with us is entered electronically.
- The doctor cannot see you until your medical/surgical history, family history and all medications with dosage and prescribing information are entered into our EMR system. Please remember to bring your **completed new patient paperwork with you to your appointment**. Please do **NOT** come to your appointment and expect to complete these forms when you arrive. We may have no choice but to reschedule your appointment. We sincerely hope you understand and will comply with this important aspect of your new patient appointment and care.
- Our doctors specialize in Urology, which deals with issues concerning the urinary bladder, kidneys, prostate and other urinary concerns. The first step in detecting a urinary issue is to test a urine specimen. **PLEASE BE PREPARED TO LEAVE A URINE SPECIMEN AT EVERY APPOINTMENT AFTER YOU CHECK IN.**
- Please bring all of your medications, in a zip lock bag, in their respective pharmacy provided bottles, with you to your visit so that we may have a current and accurate listing of your medications. Please also include any over the counter medications and vitamin/mineral supplements.
- If you have been referred to our practice for an elevated PSA, please bring those test results with you to your appointment. This information is crucial to planning your care. **PLEASE DO NOT RELY ON YOUR REFERRING DOCTOR'S OFFICE TO SEND US THOSE RESULTS.**
- Please bring **X-ray films, CD image discs and any reports** relative about any radiology testing you may have had. We do not want to duplicate the same tests or delay your care.
- Please bring your most current valid insurance card(s), both primary and secondary, as well as a valid driver's license and your applicable co-pay. Our office accepts cash, check, MasterCard, Visa, American Express and Discover. The omission of any of these will require rescheduling your appointment.

Thank you, in advance, for being a partner in your care.

Premier Urology Corp.

Patient Demographic Information

Patient Name _____
First Middle Initial Last

Address _____
Street City State Zip

SSN _____ DOB _____ Please circle: Male Female Single Married Divorced

Race: Asian Native Hawaiian Other Polynesian African American Native American White Other

Ethnicity: Hispanic Non-Hispanic All Others Primary Language: English Spanish Other: _____

Home Phone_____ Work Phone_____ Cell Phone_____

Email _____ Smoke: Y N Alcohol: Y N

Referring Doctor _____ Phone Number_____

Family Doctor _____ Phone Number_____

Employer _____ Phone Number_____

Pharmacy _____
Name Phone Number

_____
Street City State Zip

Primary Insurance:		Secondary Insurance:	
Insurance Co	_____	Insurance Co	_____
ID Number	_____	ID Number	_____
Group Number	_____	Group Number	_____
Subscriber	_____	Subscriber	_____
Subscriber DOB	_____ SSN_____	Subscriber DOB	_____ SSN_____
Relationship to Patient	_____	Relationship to Patient	_____

Emergency Contact_____ Relationship _____
Phone _____ Alt Phone _____
Closest relative not living with you_____ Relationship to Patient _____
Address _____ Phone_____

How did you hear about out practice?_____

- I authorize Premier Urology Corp. and Dr. David H. Brown to release my mail or fax to any third party payer, such as an insurance company or government agency, any medical information contained in my records when such material is required in connection with determining a claim for payment.
- I authorize Premier Urology Corp. and Dr. David H. Brown to release by; mail or fax any medical information accumulated in the course of my examination or treatment to my referring doctors and/or any other requesting doctor, hospital or nursing home.
- I authorize payment directly to Premier Urology Corp. for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance and/or Medicare.
- I hereby accept financial responsibility for payment of services not covered by Medicare or my insurance company.

Patient or Responsible Party Signature_____ Date_____

Premier Urology Corp.

Consent for Release of Information to Family Members

Patient Name_____

I authorize *Premier Urology Corp.* to share information regarding my medical condition with the following individuals or family members (please list the name of those all appropriate individuals below). **If no names are specifically listed here, we are unable to speak with anyone about you or your care should they call on your behalf.**

_____

_____

_____

_____

_____

_____

I will contact *Premier Urology Corp.* in writing should the list of authorized individuals change after this consent is signed.

Patient Signature_____ Date_____

Premier Urology Corp.

HIPAA Privacy Notice Summary

Premier Urology Corp. is committed to providing quality care to our patients and maintaining their protected health information in a safe and confidential manner. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your protected health information (i.e. individually identifiable information such as names, dates, phone/fax numbers, email address, home address, social security numbers and demographic data) may be used disclosed by us in one or more of the following respects:

- To other health care providers (i.e. your family doctor, referring physicians, etc.) in connection with our rendering urologic care to you.
- To third party payers and insurance companies in order to obtain payment of our account and to verify coverage for services rendered.
- Internally to all staff members who have any role in your treatment.
- To your family members and significant others who you authorize and identify as being involved in your treatment and care.
- We may contact you by phone or mail to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other use or disclosures of your protected health information will be made only after obtaining written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to.

1. Request restrictions on the use and disclosure of your protected health information.
2. Request confidential communication of your protected health information.
3. Inspect and obtain copies of your protected health information through asking us.
4. Amend or modify your protected health information in certain circumstances.
5. Receive an accounting of certain disclosures made by us of your protected health information.
6. You may, without risk or retaliation, file a complaint as to any violation b us of your privacy rights with us (by submitting inquiries to our Privacy Officer at our corporate office location) or the United State Secretary of Human services (which must be filed within 180 days of the violation.)

We have the following duties under the privacy rules:

1. By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information.
2. To abide by the terms of our Privacy Notice that is currently in effect.
3. To advise you of our right to change the terms of our Privacy Notice and to make the new notice provisions effective for all health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

1. Honor any request by you to restrict the use or disclosure of your protected health information.
2. Amend our protected health information if, for example, it is accurate and or complete.
3. Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

I have received and read a copy of the “HIPAA Privacy Notice Summary” in common language and understand that an expanded version is available to me in the office for review in further detail.

Patient Name_____ Date_____

PREMIER UROLOGY CORP.
Patient Information

Name _____ Age _____ DOB _____ Date: _____

Reason for Visit: _____ Referring Doctor _____

Height _____ Weight _____ E- MAIL: _____

Urologic History: Are you experiencing any of the following:

Unexplained Weight Loss	____	Lower Extremity Weakness	____
Dry Skin	____	Rash	____
Dry Eyes	____	Difficulty Walking	____
Dry Mouth	____	Psychiatric Problems	____
Leg Swelling	____	Impaired Sex Drive	____
Shortness of Breath	____	Easy Bleeding	____
Constipation	____	Involuntary Urine Loss	____

Past Medical History: Have you ever had any of the following conditions:

High blood pressure	____	Anemia	____	Kidney stones	____
Heart disease	____	Blood Clots	____	Erectile Dysfunction	____
Diabetes	____	Blood Disease	____	Prostatitis	____
Stroke	____	Migraines	____	High Cholesterol	____
Emphysema	____	Seizures	____	Cancer	____
Hypothyroid	____	Ulcers	____	Type _____	____
Gout	____	Acid Reflux	____	Fibromyalgia	____
Hematuria	____	Hydronephrosis	____	Hyperthyroid	____

Family History:

Cancer _____
Diabetes _____
Leukemia _____
Heart Disease _____
High Blood Pressure _____

List any surgeries you have had with Dates:

Surgery	*Date*

Do you have a pacemaker? _____ Defibrillator? ____ Artificial heart valve? _____

ALLERGIES:	**Type of Reaction**

Do you take Glucophage or Metformin? _____
Do you have a Shellfish Allergy? _____
Do you have an allergy to X-ray dye? _____
Do you have a latex allergy? _____
Are you currently in a pain clinic or being prescribed pain medications by another physician? _____

Do you Smoke? _____
How much? _____
Years smoked? _____
Years quit? _____
Alcohol Use? _____

PHARMACY :
Name: _____
Location: _____
Phone #: _____

List all MEDICATIONS AND DOSE you are taking, including Aspirin, Vitamins, and herbals: