JUA JACKSON UROLOGICAL ASSOCIATES, PC

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Administrator

Dear Patient,

Thank you for selecting Jackson Urological Associates, PC as your urological healthcare provider.

We wish to make your first visit to our clinic a pleasant experience. In an effort to reduce your wait time on your first visit, please complete ***ALL*** information on the enclosed paperwork ***prior to your arrival. Failure to bring any of this information may result in the delay of your appointment and might possibly result in the unfortunate rescheduling of your appointment until the information can be obtained.***

IF YOU HAVE HAD X-RAYS OR CT SCANS AT ANOTHER FACILITY AND ARE BEING REFERRED TO THIS CLINIC, PLEASE MAKE SURE THAT YOU BRING THE X-RAY FILMS AND/OR DISCS AND THE WRITTEN REPORT. THE WRITTEN REPORT MAY ALSO BE FAXED BY THE REFERRING DOCTOR TO 731.427.9973.

Please bring your current insurance card(s) and be prepared to pay any co-payments prior to being seen by the physician. All patients are responsible for knowing whether or not their insurance ***requires a written referral from their primary care physician.*** Accordingly, if a referral is required, it is the *patient's* ***responsibility to obtain this referral*** and have the referral available on the date of the appointment. ***Jackson Urological Associates will not be responsible for obtaining these referrals!***

Some insurance plans require that only certain hospitals be used in case hospitalization is required during your treatment. Also, some plans require that certain outside reference labs be used if we must perform any lab tests. It is each patient's responsibility to know this information and to inform the receptionist, nurse or insurance departments of these special requirements before the services are performed.

If you have any questions prior to your appointment, please feel free to call. If you are unable to keep your appointment, please call our office to cancel or reschedule.

Thank you,

Jackson Urological Associates, PC

Main Office: 28 Medical Center Drive - Jackson, TN 38301 - (731) 427-9971 - 1-800-748-9855 - Fax (731) 427-9973
North Office: 379 Hospital Blvd. - Jackson, TN 38305 - (731) 240-1777 - Fax (731) 427-9973

JUA JACKSON UROLOGICAL ASSOCIATES, PC

JACKSON UROLOGICAL ASSOCIATES, PC

Today's Date: ______________________________

Preferred Pharmacy

Pharmacy Name:______________________Phone #:__________Fax#:__________
Address:____
City:____________________State:______________Zip______________
Primary Care Provider:__________________Referring Provider:__________________

Patient Information

Last Name:__________________First:.______________Middle:__________
Preferred Name:____________Prefix: Dr.__Miss__Mr.__Mrs.__Ms.__ Suffix:________
DOB:__________Sex:________SSN:______________Race:__________
Marital Status: ( )Divorced ( ) Married ( )Single ()Separated ()Widowed Driver License #:__________
Mailing Address______________________________________
Zip:__________City:____________________State:______________
Phone: Home:__________Work:__________Cell:__________Primary: ( )Home ( )Cell
Fax#: Email address:______________________
Emergency Contact: (not spouse) Relationship:__________Phone #:__________
Patient's Employer:__________________________Occupation:__________
Employer Address:______________________________________
Zip:__________City:____________________State:______________

Spouse Information

Last Name:__________________First:______________Middle:__________

Responsible Party Information (complete only if patient is a minor)

Last Name:__________________First:______________Middle:__________
DOB:______________________SS#:______________________
Relationship to patient: ( ) Father ( ) Mother Other, please specify:__________________
Mailing address (if different from patient):______________________________
Zip:__________City:____________________State:______________
Employer:____
Employer Address:____
Employer Phone #:______________________Employer Fax#:______________

Insurance Information

Primary:______________________________Policyholder:______________
Relationship to patient:______________DOB:______________SS#:__________
Policyholder's Employer: ______________________Phone:______________
Employer Address:______________________________
Zip:__________City:____________________State: ______________
Subcriber/1D#:______________________________Group#______________
Secondary:______________________________Policyholder:______________
Relationship to patient:______________DOB:______________SS#:__________
Policyholder's Employer: ______________________ Phone: ______________
Employer Address: ______________________________
Zip:__________City:____________________ State: ______________
Subcriber/1D#:______________________________ Group#: ______________

JACKSON UROLOGICAL ASSOCIATES

I. INSURANCE INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. authorize my physician to release any information required to process my claim. I agree that I am financially responsible for all services provided and should ii be necessary to refer the account to collection I will be responsible for all fees including, but not limited to, collection costs, attorney fees and court costs involved with my account.

II. FINANCIAL POLICY

Our office is committed to providing quality and cost-effective healthcare to our patients. We stress that it is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorization or referrals prior to your appointment. Your doctor may recommend services he/she feels are beneficial but may not be covered by insurance. It is your responsibility to understand the limit and restrictions affecting coverage for these services. *If* ***your insurance company requires you to use a specific lab or hospital, it is your responsibility to notify us of this.*** Insurance reimbursement is a contract between you and your insurance company. As a courtesy to you, we file all claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of all changes in insurance status. You will be responsible for all co-pays, deductibles, co-insurance amounts along with the entire amount of any non-covered services. Payment for services is expected at the time they are rendered unless other arrangements have been made with our business office. For your convenience, we accept cash, money order, personal checks and all major credit cards. We also realize that healthcare is sometimes an unplanned event so we **will** attempt to accommodate your personal needs as circumstances require. In order to best meet your needs, please call our business office at (731) 427-9971 with any questions you may have regarding our financial policy and procedures. Patients who do not have insurance coverage (or proof of coverage) or who choose to pay for non-covered services are expected to pay in full at the time of the service. If you cannot pay the full amount then you must make satisfactory payment arrangements with our business office prior to receiving services.

III. PREVENTIVE CARE SERVICES

Your health plan may not provide benefits for preventative services. It is important you determine if your plan offers benefits for this service and their guidelines for it. We use industry standard codes and guidelines to submit insurance claims based on the encounter and documentation in the medical record. Current laws regarding fraud/abuse with billing procedures prohibit us from changing the procedure and/or diagnosis codes in order to get the claim paid by the insurance company.

IV. NOTICE OF PRIVACY PRACTICES -ACKNOWLEDGEMENT

You have the right to obtain and read our Notice of Privacy Practices before you decide whether to sign this consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

D I **DO ELECT** to receive a copy of the Notice of Privacy Practices. (Copy given by:____________________________**Ti:tl**

o I ***DO NOT ELECT*** receive a copy of the Notice of Privacy Practices.

XSIGNATURE:____**DATE:**_______________________________

(Signature required here. This applies to sections I, 11, II and **IV.)**

V. AUTHORIZATION TO SHARE HEALTHCARE INFORMATION

(This clinic will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.) ***This authorization ends only upon my written request.*** I permit you to share my healthcare information with:

NAME ____RELATIONSHIP: ______________________________

NAME____RELATIONSHIP: ______________________________

NAME____RELATIONSHIP: ______________________________

NAME____RELATIONSHIP: ______________________________

Please check all that apply.

( ) All healthcare information in my record
( ) Only personal information
( ) Insurance & billing information
( ) Other____

X SIGNATURE: **DATE:**

(Signature required ere *ONLY* if you are authorizing sharing of healthcare information. This appH s to section V.)

Jackson Urological Associates, PC

Patient History Form

TODAY'S DATE_____/_____/_____ DATE OF LAST PHYSICAL EXAM_____/_____/_____

LAST NAME______________________FIRST NAME______________________MIDDLE ________________

SOCIAL SECURITY NUMBER____________________________________DATE OF BIRTH ______/_____/_____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail.)

____

____

____

History of Present Illness

Please answer the following questions.

Location of the problem

Abdomen Back Leg

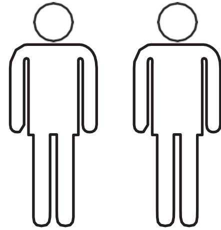
Other______________________

____

____

____

____



On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem:

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other____________________________________

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other____

How long does the problem last?

30 minutes 1 hour It is always there

Other____

Is anything else occurring at the same time?

Yes **No** If yes, please explain

Nausea Rash Headaches

Other____

Is the problem constant or variable?

Dull then sharp Very sharp then leaves Always there

Other____

Does the problem interfere with your normal function?

Yes If yes, please explain _____________

____

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

JACKSON UROLOGICAL ASSOCIATES, PC
PERSONAL HEALTH HISTORY QUESTIONNAIRE

Name:____Date:__________Date of Birth___________M_____F_______

Reasonfor visit: ____

Past Medical History

_____Arthritis
_____Asthma
_____Cancer
_____Cataracts
_____Cirrhosis
_____Clotting Disorder
_____Congestive Heart Failure
_____Diabetes
_____Emphysema
_____Gallstones
_____Glaucoma
_____Gout
_____HIV/AIDS
_____Heart Attack
_____Heart Disease
_____Hepatitis
_____Hernia
_____High Blood Pressure
_____Kidney Disease
_____Kidney Stones
_____Mental Illness
_____Pancreatitis
_____Pneumonia
_____Prostate Problems
_____Rheumatic Fever
_____Seizures
_____Sexually Transmitted Disease
_____Stomach Ulcers
_____Stroke
_____Thyroid Disease
_____Tuberculosis
_____Urinary Tract Infections

List any other current or past illnesses not mentioned and the date that they occurred:
1.____5.____
2.____6.____
3.____7.____
4.____8.____

List operations, hospitalizations, and injuries and the year in which they occurred:
1.____5.____
2.____6.____
3.____7.____
4.____8.____

Current Medications: (include doses and any nonprescription drugs or herbs)
____
____
____
____

Allergies (list all known allergies, especially to medications)
____ Reaction:__________________________________
____ Reaction:__________________________________
____ Reaction:__________________________________

Social History:
Marital Status: M_____W____S______D_______Occupation_:____
Smoking: (packs per day and # of years)_______________Alcohol Use:_____________Recreational Drugs:__________

Family Medical History:
Please list any family members (Mother, Father, Siblings, and Grandparents) with the following illnesses:

Disease	**Family Member**	**Disease**	**Family Member**
Blood Clotting Disorder		Prostate Cancer	
Breast Cancer		Seizures	
Colon Cancer		Stroke	
Diabetes		Thyroid Disease	
Heart Disease		Tuberculosis	
High Blood Pressure		Other Cancers	
Kidney Disease		Other Diseases	
Liver Disease			

Living (age)/Deceased (age of death) Cause of Death Disease
Father:____
Mother:____
Siblings: ____

Females Only: OB/GYN History: Age at first period:________Frequency:______________
Duration:_______________________
Number of pregnancies___________Obstetrical Complications ____________________________________

Tests (Please Give the Year of the Most Recent Test or Immunizations)

Pap Smear	Chest X-Ray	Flexible Sigmoidoscopy	Mammogram
Flu Shot	TB Skin Test	EKG	Cholesterol
Tetanus	Colonoscopy	Pneumovax	

Name ___________________________________DOB________________Social Security#:___________________

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.
Please explain any yes answers in space provided.

Constitutional Symptoms

Fever	y	**N**
Chills	y	**N**
Headache	y	**N**
Other		

Eyes

Blurred Vision	y	**N**
Double Vision	y	**N**
Pain	y	**N**
Other		

Neurological

Tremors	y	**N**
Dizzy Spells	y	**N**
Numbness/Tingling	y	**N**
Other		

Endocrine

Excessive Thirst	y	**N**
Too Hot/Cold	y	**N**
Tired Sluggish	y	**N**
Other		

Gastrointestinal

Abdominal Pain	y	**N**
NauseaNomiting	y	**N**
Indigestion/Heartburn	y	**N**
Other		

Cardiovascular

Chest pain	y	**N**
Varicose Veins	y	**N**
High Blood Pressure	y	**N**
Other		

Integumentary

Skin Rash	y	**N**
Boils	y	**N**
Persistent Itch	y	**N**
Other	______	

Musculoskeletal

Joint Pain	y	**N**
Neck Pain	y	**N**
Back Pain	y	**N**
Other	______	

Ear/Nose/Throat/Mouth

Ear Infection	y	**N**
Sore Throat	y	**N**
Sinus Problems	y	**N**
Other	______	

Genitourinary

Urine Retention	y	**N**
Painful Urination	y	**N**
Urinary Frequency	y	**N**
Other	______	

Respiratory

Wheezing	y	**N**
Frequent Cough	y	**N**
Shortness of Breath	y	**N**
Other	______	

Hematological/Lymphatic

Swollen Glands	y	**N**
Blood Clotting Problem	y	**N**
Other	______	

Psychological

Are you generally satisfied with your life?	y	**N**
Do you feel severly depressed/anxious?	y	**N**
Have you considered suicide?	y	**N**

Other ____________________________________

Physician ____ Date: ____ /____ /___ _