Date: _____ Referred by:_____

Patient's Name: _____
First Middle Last Maiden Preferred Name

Address:_____City/State/Zip_____

Sex: M F Are You (circle one): Single Divorced Separated Married Widowed

Race: _____ Ethnicity: _____ Preferred Language: _____

Employer: _____ Employer Phone: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Birth Date: _____ Social Security #: _____

Do you have any personal, moral, or religious objection to any of the usual forms of medical treatment including blood transfusion? Yes No
Do you have a living will, DNR, no CPR, end-of-life, or power of attorney? Yes No If yes, please circle appropriate one.

PLEASE NOTE: Payment is due at the end of each visit. If other arrangements are needed you may check with the office manager. If you are covered by Medicare and/or Welfare, please present your cards when you arrive at the office each visit.

Primary Insurance	Secondary Insurance
_____	_____
Name of Insurance Company	Name of Insurance Company
_____	_____
Policyholder SS#	Policyholder SS#
_____	_____
Policyholder's Address	Policyholder's Address
_____	_____
Relationship to You Date of Birth	Relationship to You Date of Birth
_____	_____
Employer	Employer

Assignment of Benefits

I request that payment of any of my insurance medical and/or surgical benefits be made directly to Wikoff Urology, PA, on any claim filed by him or his agents on my behalf for service furnished me by this physician. I authorize him or his agents as holder of medical information on me to release any information needed to determine these benefits payable for related services.

Patient Signature:_____ Date:_____

List your nearest relative or friend who does not live with you, to contact in case of emergency.

Name: _____ Relationship to you: _____

Address:_____ Phone: _____

NEW PATIENT HISTORY FORM

Patient Name:_____Today's date:_____
Date of Birth:_____
Referring Physician:_____
Family doctor's name:_____Heart doctor's name:_____
Reason for visit today:_____
Do you have any **medication allergies?** ***YES or NO***
If so, what medication(s)?_____

YOUR SYMPTOMS RECENTLY

Please understand that it is important for us to know all of your medical problems in order to provide safe and appropriate care.

Pain with urinating
Blood in the urine
Urinary frequency
Delays in starting urination
Stream that starts and stop
Burning sensation
Dribbling after urination
Urine leakage before reaching bathroom
Leakage with laughing, coughing, or sneezing
Urination during the night

Feeling poorly
Nausea
Constipation
Diarrhea
Pain in flank
Pain in low back
Abdominal swelling
Recent weight loss
Decreased appetite
Bone pain
Easy Bleeding

Other(s):_____
_____
_____
_____

MEN ONLY:

Testicular pain
Testicular swelling
Trauma to genital region
Trauma to back
Pain in scrotum
Scrotal swelling
Inadequate erection
Unable to perform sex

WOMEN ONLY:

Vaginal itching or burning
Vaginal pain during sex
Use of fingers to pass stool
# of previous pregnancies___
# of cesarean sections_____
# of vaginal deliveries_____
Prior pelvic floor surgery?
YES or NO

(MEN ONLY)
Lack of morning erections
Unable to maintain erection
Changed sexual interest
Penile curvature with erection
Feeling tired
Overall decrease in strength

(WOMEN ONLY)
Surgery on abdomen?
YES or NO
Taking Hormones?
YES or NO

PAST MEDICAL HISTORY

(If you have had any of the problems below, please circle them).

Alzheimer's Disease
Arthritis
Asthma
Cancer
COPD (lung disease)
CHF (heart failure)
Coronary Artery Disease (CAD)
Diabetes
GERD (acid reflux)
Glaucoma
High Blood Pressure
High Cholesterol/Lipids
Mental Illness
Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease (PVD)
Stroke (CVA)
BPH (enlarged prostate)
Bladder Cancer
Erectile Dysfunction
Kidney Stones
Prostate Cancer
Sexually Transmitted Disease
Trauma/Injury
Urinary Tract Infection (UTI)
Other_____
_____
_____
_____
_____
_____
_____
_____
_____

PAST SURGICAL HISTORY

(Please circle any surgeries you have had).

Angioplasty
Appendectomy
Back Surgery
CABG (open heart surgery/ bypass graft)
Cataract Surgery
Cholecystectomy (Gallbladder removed)
Hernia repair
Hysterectomy
Joint Replacement
Pacemaker Placement
Salpingectomy/Oopherectomy (ovaries removed)
Tonsillectomy
Tubal ligation

Other(s)_____

SOCIAL HISTORY

(Circle answers or fill in the blanks)

Alcohol Intake? Daily, Weekly, Occasionally, or Never
Caffeine Intake? *YES or NO*. How many cups per day?_____
Exercise Habits:_____
Occupation:_____
Under Stress? *YES or NO*
Smoker: current everyday, current somedays, former, never
how much _____
Smokeless tobacco: current everyday, current somedays, former, never
how much _____

Religious affiliation_____

FAMILY HISTORY

(Do you have family members with these problems? Please circle *Yes* or *No* and fill in blanks).

Cancer? *YES or NO* What type and who:_____
Diabetes? *YES or NO*
Prostate Cancer? *YES or NO* Which family member?_____
Stroke? *YES or NO*
Heart Disease? *YES or NO*
High Blood Pressure? *YES or NO*
*Other(s)*_____

OTHER REVIEW OF SYSTEMS

(If you have any of the problems below, please circle them).

Skin rash
Itchy skin
Wound slow to heal
Headache
Dizziness
Double vision
Eye pain
Blurry vision
Ear pain
Sinus
Sore throat
Neck pain
Thirst
Heartburn
Chest pain at rest
Chest pain with activity
Heart palpitations
Shortness of breath
Wheezing
Coughing
Abdominal pain
Low back pain
Joint pain
Leg pain
Numbness
Involuntary movements
Sleep disturbances
Anxiety
Depression
Other(s)_____
_____
_____

Wikoff Urology Patient Portal

We are now required by the new healthcare laws to provide you with a summary of your office visit within 3 business days of your visit. You may come back by our office and pick this up or you may sign up on our secure patient portal and have this emailed to you.

Our patient portal is a secure website which allows you to:

Contact your physician

View your account statement

Update your personal information

Request an appointment

Request a prescription refill

Ask a billing question

Ask other questions

You may also see a summary of your medical information, complete patient forms, or view your latest healthcare information. This website allows you to communicate with us through a secure email.

You may access this website at https://wikoffurology.portalforpatients.com or log onto our website at www.wikoffurology.com and click on the patient portal link.

Please ask for a PIN number if you would like to access this secure website.

❑ I wish to sign up for the patient portal.

❑ I do not wish to sign up for the patient portal. I understand that a copy of my office visit summary will be available for me to pick up with 3 business days.

Patient signature: _____ Date: _____

Patient name printed: _____

Patient Medication List

Name: __________________________________ Date: __________

Pharmacy: ____

Medication	Dosage	How Many Times Per Day

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I,_____, understand that as a part of my healthcare, Wikoff Urology, P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that Wikoff Urology, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Wikoff Urology, P.A. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Wikoff Urology, P.A. change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or If I agree, email).

I understand that as part of this organization's treatment, payment or heatlh care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept** the terms of this consent. Patient signature_____ Date_____

I fully understand but **decline** the terms of this consent. Patient signature_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Wikoff Urology, P.A. ***Notice of Privacy Policies,*** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my personal medical information:_____

_____

_____

Patient Signature_____ Relationship_____ Date_____

FOR OFFICE USE ONLY

☐ Consent received by_____on _____

☐ Consent added to patients medical record on _____by_____

☐ Consent refused by patient and treatment refused as permitted.

PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY/PROVIDER OF CARE

I understand that Wikoff Urology, P.A. and the office staff is authorized by me to disclose my protected health information by telephone or in person to only the people that I have listed below.

Name_____ Relationship_____

Phone Number _____ ☐ Medical Info ☐ Appts/Testing

Name_____ Relationship_____

Phone Number _____ ☐ Medical Info ☐ Appts/Testing

Name_____ Relationship_____

Phone Number _____ ☐ Medical Info ☐ Appts/Testing

Home Health Agency _____ ☐Medical Info ☐Appts/Testing

I wish to be contacted in the following manner in regards to my medical information, appointments and testing:

☐ Home Phone _____ ☐ Okay to leave message with detailed information
☐ Leave message with callback number only

☐ Work Phone_____ ☐ Okay to leave message with detailed information
☐ Leave message with callback number only

☐ Written Communication ☐ Okay to mail to my home ☐ Okay to mail to my home/office ☐ okay to fax _____

☐ Other_____

I understand that I have the right to revoke anyone listed on the authorization and fill out the form before the revocation can be completed.

All revocations must be sent to Wikoff Urology, P.A. to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

I fully understand and **accept** the terms of this authorization. Patient Signature_____ Date_____

I fully understand but **decline** the terms of this authorization. Patient Signature_____Date_____

++

FOR OFFICE USE ONLY

☐ Consent received by_____on _____
☐ Consent added to patients medical record on _____by_____
☐ Consent refused by patient and treatment refused as permitted.