LOUISIANA UROLOGY, LLC

8080 Bluebonnet Blvd., Suite 3000
Baton Rouge, Louisiana 70810
Office 225.766.8100 • Fax 225.408.6873

PATIENT INFORMATION

Account # _____ F/C _____

Resp Party # _____ DR _____ LOC _____

PATIENT INFORMATION

Patient _____
First Middle Last Suffix (Jr., Sr., Other)

Mailing Address _____
Street City State Zip

Social Security _____ Date of Birth _____ Marital Status _____ Sex M or F

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____ Emerg Contact Name & Number _____

Referring Doctor _____ Primary Care Doctor _____

Employer _____ Employment Status _____ Student ❑ Full-Time ❑ Part-Time

How did you hear about our clinic? ❑ Friend ❑ Internet ❑ Physician ❑ Relative ❑ TV

❑ Yellow Pages ❑ Other _____

Race ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American

❑ Native Hawaiian or Other Pacific Islander ❑ Other Race ❑ Two or More Races

❑ White Preferred Language _____

Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino Preferred Pharmacy _____

If patient is a child, Responsible Party _____

Family Physician _____ Who were you Referred By _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder _____ Birth Date _____

Insurance ID# _____ Group # _____

Secondary Insurance _____

Policy Holder _____ Birth Date _____

Insurance ID# _____ Group # _____

X _____ Date _____

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WAIVER

MEDICAL INFORMATION WAIVER

In an effort to provide you with timely information regarding your health care, we are asking that you complete this waiver:

Please provide us with phone numbers where you would like us to **contact you with test results and medical information.**

Home _____ **Work** _____

Cell _____ **Fax** _____

If you are unavailable when we call you, please list the name and telephone number of any other person(s), i.e. husband, wife, child, etc., authorized to receive and discuss your personal medical information?

Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone

❑ I do not authorize anyone to receive information regarding my care.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been presented with a copy of this provider's 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 my personal medical information:

_____

If you are not available at the time we try to call you, may we leave medical information on your **answering machine** or **voicemail**?

❑ **Yes** ❑ **No**

(If your answering machine does not identify your last name or phone number, we will not leave medical information.)

I WISH THIS WAIVER TO REMAIN IN EFFECT UNLESS I RESCIND IT IN WRITING.

Signature: _____ **Printed Name:** _____

Today's Date: _____

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PATIENT HISTORY

Patient Name _____

THE FOLLOWING INFORMATION IS VERY IMPORTANT TO YOUR HEALTH. PLEASE TAKE TIME TO FULLY AND COMPLETELY FILL OUT THIS IMPORTANT INFORMATION. WE ARE COUNTING ON YOU.

First _____ Last _____ Middle _____

Date of Birth _____ Today's Date _____

What is the reason for your visit today? _____

_____

_____

ALLERGIES TO MEDICATIONS

List All Allergies to Medications (including iodine and shellfish allergies) _____

_____

Reaction _____

Have you ever had any problems with Anesthesia? ❑ Yes ❑ No

If ☑ Yes, please explain: _____

Pharmacy Name _____ Pharmacy Phone Number _____

Medication Name	Dose	How Much and How Often Taken

PAST MEDICAL HISTORY

Please check those that apply to you

❑ Asthma
❑ Cancer (Type_____)
❑ Diabetes
❑ Depression
❑ Emphysema
❑ Glaucoma
❑ Heart Disease
❑ Hepatitis (Type_____)
❑ High Blood Pressure
❑ High Cholesterol
❑ HIV / AIDS
❑ Implanted Defibrillator
❑ Implanted Pacemaker
❑ Kidney Failure
❑ Kidney Stones
❑ Mitral Valve Prolapse
❑ Multiple Sclerosis
❑ Parkinson's Disease
❑ Previous Transfusions
❑ Thyroid Problems
❑ Tuberculosis

Other Illnesses:

_____ _____ _____

_____ _____ _____

Do you use a ventilation device such as CPAP or BIPAP? ❑ Yes ❑ No

If ☑ Yes, reason why? _____

Any implantable devices? _____ Cardiologist Name _____

Primary Care Physician Name _____

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PATIENT HISTORY

Patient Name _____

FAMILY HISTORY

Please check and list the family member's relationship to you

Has anyone had prostate cancer? ❑ Yes ❑ No Who? _____
Has anyone had bladder cancer? ❑ Yes ❑ No Who? _____
Has anyone had kidney cancer? ❑ Yes ❑ No Who? _____
Has anyone had kidney stones? ❑ Yes ❑ No Who? _____
Has anyone had complications with anesthesia? ❑ Yes ❑ No Who? _____
List any other immediate family member's serious illnesses _____

PAST SURGICAL HISTORY

List all of your prior operations and dates performed

Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____

SOCIAL HISTORY

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Annulled ❑ Life Partner ❑ Unknown
Smokeless Tobacco ❑ Yes ❑ No **Tobacco Assessment** ❑ Tobacco Use Assessment
Smoking Status *Current* ❑ Current Everyday Smoker ❑ Current Someday Smoker ❑ Former Smoker ❑ Never Smoker ❑ Smoker, Current Status Unknown ❑ Unknown If Ever Smoked ***Historical*** ❑ Former Smoking Status
Counseling Provided ❑ Smoking Cessation Counseling Provided
How many caffeinated drinks do you have each day? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4+
Do you drink Alcohol ❑ Yes ❑ Not Anymore ❑ Never Drank **Do you use Recreational Drugs?** ❑ Yes ❑ No
Have you had a blood transfusion? ❑ Yes ❑ No **Occupation** _____ **Industry** _____
Race(s) ❑ American Indian or Alaska Native ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ Unknown ❑ More Races ❑ Asian ❑ Declined to Specify ❑ Other Race ❑ White
Ethnicity ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Declined to Specify ❑ Unknown ❑ More
Preferred Language ❑ English ❑ Spanish; Castilian ❑ French

REVIEW OF SYSTEMS — MEN ONLY

Check the symptoms you currently have or have had in the past year? Please check all that apply.

Fever ❑ Yes ❑ No	Abdominal Pain ❑ Yes ❑ No	Fibromyalgia ❑ Yes ❑ No	UTIs ❑ Yes ❑ No
Chills ❑ Yes ❑ No	Bloody Stool ❑ Yes ❑ No	Gout ❑ Yes ❑ No	Blood in Urine ❑ Yes ❑ No
Weight Gain ❑ Yes ❑ No	Constipation ❑ Yes ❑ No	Joint Pain ❑ Yes ❑ No	Asthma ❑ Yes ❑ No
Weight Loss ❑ Yes ❑ No	Heartburn ❑ Yes ❑ No	Leg Pain ❑ Yes ❑ No	Cough ❑ Yes ❑ No
Blurred Vision ❑ Yes ❑ No	Hernia ❑ Yes ❑ No	Leg Swelling ❑ Yes ❑ No	Emphysema ❑ Yes ❑ No
Cataracts ❑ Yes ❑ No	Nausea ❑ Yes ❑ No	Neck Pain ❑ Yes ❑ No	Shortness of Breath ❑ Yes ❑ No
Glaucoma ❑ Yes ❑ No	Vomiting ❑ Yes ❑ No	Dry Mouth ❑ Yes ❑ No	Anemia ❑ Yes ❑ No
Pain ❑ Yes ❑ No	High Blood Pressure ❑ Yes ❑ No	Hearing Loss ❑ Yes ❑ No	Aspirin Use ❑ Yes ❑ No
Glasses / Contacts ❑ Yes ❑ No	High Cholesterol ❑ Yes ❑ No	Nosebleeds ❑ Yes ❑ No	NSAID use ❑ Yes ❑ No
Drug Allergies ❑ Yes ❑ No	Chest Pain ❑ Yes ❑ No	Sinus Problems ❑ Yes ❑ No	Bleeding Disorder ❑ Yes ❑ No
Food Allergies ❑ Yes ❑ No	Irregular Heart Rate ❑ Yes ❑ No	Vertigo ❑ Yes ❑ No	Hepatitis ❑ Yes ❑ No
Seasonal Allergies ❑ Yes ❑ No	Heart Failure ❑ Yes ❑ No	Abnormal PSA ❑ Yes ❑ No	HIV/AIDS ❑ Yes ❑ No
Balance Problems ❑ Yes ❑ No	Heart Attack ❑ Yes ❑ No	Curved Penis ❑ Yes ❑ No	Swollen Glands ❑ Yes ❑ No
Numbness ❑ Yes ❑ No	Boils / Abscesses ❑ Yes ❑ No	Erection Difficulties ❑ Yes ❑ No	Cancer ❑ Yes ❑ No
Migraines or Headaches ❑ Yes ❑ No	Breast Changes ❑ Yes ❑ No	Kidney Failure ❑ Yes ❑ No	Generally Satisfied with Life ❑ Yes ❑ No
Seizures ❑ Yes ❑ No	Dry Skin ❑ Yes ❑ No	Kidney Stones ❑ Yes ❑ No	Anxiety ❑ Yes ❑ No
Stroke ❑ Yes ❑ No	Itchy Skin ❑ Yes ❑ No	Lump in Testicles ❑ Yes ❑ No	Depression ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No	Psoriasis ❑ Yes ❑ No	Penis Discharge ❑ Yes ❑ No	OCD ❑ Yes ❑ No
Pituitary Problem ❑ Yes ❑ No	Skin Rash ❑ Yes ❑ No	Sore on Penis ❑ Yes ❑ No	Schizophrenia ❑ Yes ❑ No
Thyroid Problem ❑ Yes ❑ No	Arthritis ❑ Yes ❑ No	Urinary Frequency ❑ Yes ❑ No	Suicidal Thoughts ❑ Yes ❑ No
Tired / Sluggish ❑ Yes ❑ No	Back Pain ❑ Yes ❑ No	Urinary Retention ❑ Yes ❑ No	Other Issue ❑ Yes ❑ No

List any other problems and explain any ☑ Yes answers _____

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PATIENT HISTORY

Patient Name _____

REVIEW OF SYSTEMS WOMEN ONLY

Check the symptoms you currently have or have had in the past year? Please check all that apply.

Fever ❑ Yes ❑ No	Constipation ❑ Yes ❑ No	Leg Swelling ❑ Yes ❑ No	Generally Satisfied with Life ❑ Yes ❑ No
Chills ❑ Yes ❑ No	Heartburn ❑ Yes ❑ No	Neck Pain ❑ Yes ❑ No	Anxiety ❑ Yes ❑ No
Weight Gain ❑ Yes ❑ No	Hernia ❑ Yes ❑ No	Dry Mouth ❑ Yes ❑ No	Depression ❑ Yes ❑ No
Weight Loss ❑ Yes ❑ No	Nausea ❑ Yes ❑ No	Hearing Loss ❑ Yes ❑ No	OCD ❑ Yes ❑ No
Blurred Vision ❑ Yes ❑ No	Vomiting ❑ Yes ❑ No	Nosebleeds ❑ Yes ❑ No	Schizophrenia ❑ Yes ❑ No
Cataracts ❑ Yes ❑ No	High Blood Pressure ❑ Yes ❑ No	Sinus Problems ❑ Yes ❑ No	Suicidal Thoughts ❑ Yes ❑ No
Glaucoma ❑ Yes ❑ No	High Cholesterol ❑ Yes ❑ No	Vertigo ❑ Yes ❑ No	Endometriosis ❑ Yes ❑ No
Pain ❑ Yes ❑ No	Chest Pain ❑ Yes ❑ No	Kidney Failure ❑ Yes ❑ No	Unusual Vaginal Bleeding ❑ Yes ❑ No
Glasses / Contacts ❑ Yes ❑ No	Irregular Heart Rate ❑ Yes ❑ No	Urinary Tract Infections ❑ Yes ❑ No	Bleeding Between Periods ❑ Yes ❑ No
Drug Allergies ❑ Yes ❑ No	Heart Failure ❑ Yes ❑ No	Painful Urination ❑ Yes ❑ No	Extreme Menstrual Pain ❑ Yes ❑ No
Food Allergies ❑ Yes ❑ No	Heart Attack ❑ Yes ❑ No	Urinary Frequency ❑ Yes ❑ No	Hot Flashes ❑ Yes ❑ No
Seasonal Allergies ❑ Yes ❑ No	Boils / Abscesses ❑ Yes ❑ No	Asthma ❑ Yes ❑ No	Vaginal Discharge ❑ Yes ❑ No
Balance Problems ❑ Yes ❑ No	Breast Changes ❑ Yes ❑ No	Cough ❑ Yes ❑ No	
Numbness ❑ Yes ❑ No	Dry Skin ❑ Yes ❑ No	Emphysema ❑ Yes ❑ No	Total Pregnancies _____
Migraines or Headaches ❑ Yes ❑ No	Itchy Skin ❑ Yes ❑ No	Shortness of Breath ❑ Yes ❑ No	
Seizures ❑ Yes ❑ No	Psoriasis ❑ Yes ❑ No	Anemia ❑ Yes ❑ No	Total Deliveries _____
Stroke ❑ Yes ❑ No	Skin Rash ❑ Yes ❑ No	Aspirin Use ❑ Yes ❑ No	Vaginal Deliveries _____
Diabetes ❑ Yes ❑ No	Arthritis ❑ Yes ❑ No	NSAID use ❑ Yes ❑ No	C-Section Deliveries _____
Pituitary Problem ❑ Yes ❑ No	Back Pain ❑ Yes ❑ No	Bleeding Disorder ❑ Yes ❑ No	
Thyroid Problem ❑ Yes ❑ No	Fibromyalgia ❑ Yes ❑ No	Hepatitis ❑ Yes ❑ No	Weight of lagest baby ____ lb. ____ oz.
Tired / Sluggish ❑ Yes ❑ No	Gout ❑ Yes ❑ No	HIV/AIDS ❑ Yes ❑ No	Last Menstrual Period _____
Abdominal Pain ❑ Yes ❑ No	Joint Pain ❑ Yes ❑ No	Swollen Glands ❑ Yes ❑ No	Are you pregnant ❑ Yes ❑ No
Bloody Stool ❑ Yes ❑ No	Leg Pain ❑ Yes ❑ No	Cancer ❑ Yes ❑ No	Other Issue ❑ Yes ❑ No

List any other problems and explain any ☑ Yes answers _____

Patient or POA Statement:

I certify that the information provided on this Patient History Form is accurate and complete.
I attest that the patient's entire medical and surgical history has been listed.

Patient/POA Signature _____ Today's Date _____

Printed Patient Name _____ Date of Birth _____

PHYSICIANS USE ONLY

_____

_____

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FINANCIAL POLICY

Patient Name _____ DOB _____

FOR PATIENTS WITH INSURANCE

We are contracted with most insurance companies, but please check with your insurer to make sure that we are a participating provider for your plan. If so, we will file your claim for you if proper proof of coverage is provided to us at the time of your visit. Your insurance coverage is a contract between you and your insurer and, although we will make every reasonable effort to assist you in getting your claim paid, any charges incurred are ultimately your responsibility. Occasionally, your insurer may send you a questionnaire that must be answered before they will process your claim. Please respond to any correspondence prompty in order to expedite your claim payment.

- **Copayments:** Copayments are due at the time of service and are collected upon arrival.
- **Deductibles and Coinsurance:** Deductibles and coinsurance are due at the time of service and are collected upon arrival. We will estimate these amounts as closely as possible. Should an overpayment occur, it will be refunded to you once your insurance has paid your claim.
- **Outstanding Balances:** If you have an outstanding balance at the time of your appointment, please be prepared to pay it when you check in.

FOR PRIVATE PAY PATIENTS

Payment is required at the time of service. For new patients, please be prepared to pay **$250 for your first** appointment. If additional testing or imaging is performed, this amount may be more.

FORMS OF PAYMENT ACCEPTED

- **Cash or Money Order**
- **Checks**
- **Credit Cards:** Visa, Mastercard, Discover and American Express
- **Health Savings/Reimbursement Credit Cards:** If you have an HSA or HRA card from one of the above vendors, we can accept this just like a regular credit card as long as there are funds in the account for processing.
- **Care Credit:** For payments greater than $500

Thank you for entrusting us with your medical care. Please let us know if you have any questions or concerns.

I have read and understand the above financial policy.

_____ _____

Signature of Patient or Responsible Party Date