Bedford Regional

UROLOGY

We Get You Going

Name: ______________________ Date of Birth: ______________

PAST SURGERY HISTORY:

Please indicated whether you have had any of the following conditions.

Dental Surgery	Gallbladder Removed	Prostate Biopsy
Cardiac Cath	Hernia Repair	Prostate Resection (TURP)
Cardiac Stent	Bariatric Surgery	Prostatectomy (Suprapubic)
Heart Bypass/CABG	Colonoscopy	Prostatectomy (Radical)
Pacemaker	Knee Surgery	Cesarean Section
Blood Transfusion	Hip Surgery	D&C
Cataract Surgery	Back Surgery	Tubal Ligation
Thyroid Surgery	Kidney Surgery	Uterine Ablation
Tonsils Removed	Lithotripsy	Hysterectomy
Scope of Throat (EGD)	Kidney Removed	Prolapse Surgery
Lung Surgery	Bladder Surgery	Urethral Sling
Breast Surgery	Scope of Bladder (Cystoscope)	Transplant Surgery
Appendix Removed	Vasectomy	Other:______________

FAMILY HISTORY:

Please indicate whether anyone in your family has had the following conditions including: mother, father, sister, brother, grandfather, grandmother, aunt, uncle.

I am adopted and/or do not know my family medical history.

Diabetes ______________	Breast Cancer ______________
Heart Disease ______________	Uterine Cancer ______________
Lung Cancer ______________	Ovarian Cancer ______________
Kidney Disease ______________	Cervical Cancer ______________
Kidney Stones ______________	Colon Cancer ______________
Enlarged Prostate ______________	Prostate Cancer ______________

SOCIAL HISTORY:

Current Smoker	Smokeless Tobacco use	Alcohol Consumption
Former Smoker	Recreational/street drug use	Caffeine

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Drug Allergies (include reaction):______________________

MEDICATIONS:

List all current medications and supplements or attach separate list; **include milligram (mg) dose**.

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________

Do you see a Cardiologist? Yes No

If "Yes", Name of the Cardiologist: ______________________

PAST MEDICAL HISTORY:

Please indicate whether you have had any of the following conditions.

Stroke	Asthma	GERD	Lung Cancer
Stroke (mini)/TIA	COPD	Peptic Ulcer Disease	Breast Cancer
Alzheimer's Disease	High Blood Pressure	Crohn's Disease	Kidney Cancer
Parkinson's	High Cholesterol	Ulcerative Colitis	Bladder Cancer
MS	A. Fib	Arthritis	Prostate Cancer
Epilepsy/Seizures	CHF (Heart Failure)	Fibromyalgia	Uterine Cancer
Depression	Heart Attack	Gout	Ovarian Cancer
Anxiety	Heart Disease	Hepatitis	Cervical Cancer
Glaucoma	Blood Clots	Kidney Failure	Colon Cancer
Hypothyroidism	HIV/AIDS	Kidney Stone	Rectal Cancer
Hyperthyroidism	Diabetes:	Enlarged Prostate	Other:______________
	Type 1		
	Type 2		

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Name: ______________________ Date of Birth: ______________________

Social Security Number: ______________________ Marital Status: ______________________

Address: ____

Telephone (H): ______________________ Telephone (M): ______________________

E-Mail Address: ____

Employer: ____

Employer Address: ____

Primary MD: ______________________ Referring MD: ______________________

Pharmacy: ______________________ Laboratory: ______________________

Primary Insurance: ____

Member ID: ______________________ Group Number: ______________________

Subscriber Name: ______________________ Subscriber DOB & Social: ______________________

Secondary Insurance: ____

Member ID: ______________________ Group Number: ______________________

Subscriber Name: ______________________ Subscriber DOB & Social: ______________________

BEDFORD REGIONAL UROLOGY HIPAA/PRIVACY & BILLING AGREEMENT

I understand that as part of my health care, Bedford Regional Urology originates and maintains paper and or/ electronic records describing my health history, symptoms, examination and test results, diagnosis, 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 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 provided.

A tool for routine healthcare operation such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information 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 use of my health information for directory purposes.

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 Bedford Regional Urology is not required to agree to the restrictions requested. I understand that I may revoke this consent to 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 code of Federal Regulations.

I further understand that Bedford Regional Urology reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164-506 of Code of Federal Regulations. Should Bedford Regional Urology change their notice, they will send a copy of any revised notice to address I've provided (whether US mail or, if I agree, email).

I wish to have the following restrictions to the use or discloses of my health information:

____

I understand that as part of this organizations treatment, payment, or health 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./decline the terms of this consent.

**** I give consent for any medical information to be release to the follow individual(s), (family members, friends etc.)***

____

All professional services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for all services when rendered unless other arrangements have been made with our office.

I hereby authorize Dr. Stephen Yanoshak to release to the health care financing administration any and all information necessary to process a claim for benefits. I also authorize release of such information to any other third-party carrier and to my other health care providers.

I also authorize Dr. Stephen Yanoshak to accept payment from Medicare or any other third-party payer with the understanding that this assignment of benefits is decided on a case by case basis.

I understand that my signature in no way releases me from responsibilities for payment of charges incurred in this office, and that regardless of insurance coverage, I am ultimately responsible for a payment of my bill.

I understand that if I carry a balance for more than 90 days, that my balance may be subject to finance charges.

Patient or Legal Guardian Signature: ____

Date: ____