PATIENT INFORMATION

Today's Date: _____

Date _____ **Age** _____ **Date of Birth** _____

Patient Name _____ **Maiden Name** _____
Last First M.I.

Race: ☐ White ☐ African American ☐ Asian ☐ Hispanic ☐ Other ☐ Prefer Not To Answer

Social Security # _____ **Email Address** _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed **Gender:** ☐ Male ☐ Female

Home Address _____

City _____ **State** _____ **Zip** _____

(Please circle preferred method of contact) Home Phone_____ **Cell Phone**_____

Patient's Employer _____**Occupation** _____

Address _____ **Phone #** _____

Spouse/guardian Full Name _____**Spouse/guardian Employer** _____

Spouse/guardian Social Security # _____**Date of Birth** _____

Emergency Contact: Name _____ **Phone #** _____

Address _____**Relationship** _____

Do you have insurance that you would like us to file for you? ☐ Yes ☐ No

Insurance Company: **Primary** _____**Policyholder** _____ **Date of Birth of Policyholder**_____

Secondary _____**Policyholder** _____ **Date of Birth of Policyholder**_____

Family doctor or primary care physician _____

Did another doctor ask you to see our doctor? If yes, which doctor? _____

If no, how did you learn about our practice? ☐ Friend or Relative ☐ ER ☐ Primary Care Physician
☐ Internet ☐ Google ☐ TVUC Website ☐ Social Media ☐ Other _____

Have you ever seen Drs. Kyle, Bryan, Jackson, McIntire, Thacker, or Box before?

☐ If yes, in the office? ☐ At the hospital? **Approximate date seen** _____

Dr. Edward McIntire, M.D. • Dr. Christopher Thacker, M.D. • Dr. Daniel Box, M.D. • Dr. Alexander Ivey, M.D.
Doctor of Medicine and Surgery **Amanda Linden, FNP-C – Nurse Practitioner**

PATIENT HISTORY

Today's Date: _____

Name: _____ Date of Birth: _____
First Middle Last

Referring Physician: _____ Primary Care Physician: _____

Why are you here today? _____

Have you had any x-rays, ultrasounds, or CT scans pertinent to today's visit? YES NO

If so, did you bring a copy of the films with you today? YES NO

Where did you have the imaging done? _____

Allergies: List any medications that you are allergic to and the reaction that you have:

_____ _____

_____ _____

_____ _____

Other Allergies: List any other allergies (bee stings, etc) _____

Medications: List all of your medications and dosage (if you need more room use back of sheet)

Medication	***Dosage***	***Frequency***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What Pharmacy do you use? _____ Location: _____

Do you use a mail order pharmacy? YES NO If yes, what is the fax number? _____

Are you under the care of Pain Management? If so who is your physician? _____

Do you take any blood thinners such as aspirin, Plavix, Coumadin, Xarelto, Ibuprofen, etc? YES No

If yes, please list the medications _____

Name: _____ **Date of Birth:** _____

PAST MEDICAL HISTORY: Please mark the conditions in which you currently have or have had in the past.

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Arrhythmia (irregular heartbeat)
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis (blood clot)
- ☐ Heart Attack
- ☐ Heart Valve Problems
- ☐ Hypertension (high blood pressure)
- ☐ Stroke

Endocrine/Metabolic
- ☐ Diabetes Type I
- ☐ Diabetes Type 2
- ☐ Gout
- ☐ Hyperthyroid (high thyroid)
- ☐ Hypothyroid (low thyroid)

General
- ☐ High Cholesterol
- ☐ Polycystic Kidneys

Gastrointestinal
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ GERD / Acid Reflux
- ☐ Hemorrhoids
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Irritable Bowel Disease
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Ulcerative Colitis

Cancer
- ☐ If so, please specify type of cancer:

_____

_____

Genitourinary
- ☐ BPH (enlarged prostate)
- ☐ Chronic Renal Failure
- ☐ Elevated PSA
- ☐ Fertility Problems
- ☐ Hematuria (blood in urine)
- ☐ Kidney Cancer
- ☐ Kidney Stones
- ☐ Prostate Cancer
- ☐ Recurrent Urinary Tract Infection
- ☐ Testicular Cancer
- ☐ Bladder Cancer

GYN/OB
- ☐ Breast Cancer
- ☐ Endometriosis
- ☐ Ovarian Cyst
- ☐ Uterine Fibroids

HEENT
- ☐ Glaucoma
- ☐ Mumps

Musculoskeletal
- ☐ Arthritis
- ☐ Back Pain
- ☐ Fibromyalgia

Neuro/Psych
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Spinal Cord Injury

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ Tuberculosis

Any other conditions not listed above: _____

_____

Name: _____ **Date of Birth:** _____

PAST SURGICAL HISTORY: Please mark any surgery that you have had and indicate the year of the surgery.

Cardiovascular
- ☐ Angioplasty / Stents
- ☐ Artificial Heart Valve
  - ☐ Aortic ☐ Mitral
- ☐ Aortic Aneurysm
- ☐ Coronary Artery Bypass
- ☐ Carotid Artery Surgery
- ☐ Pacemaker or Defibrillator

General
- ☐ Brain Surgery
- ☐ Laminectomy (Back Surgery)

Gastrointestinal
- ☐ Appendectomy
- ☐ Bariatric (obesity) Surgery
  - ☐ Lapband ☐ Gastric Bypass
- ☐ Bowel (intestine/colon) Resection
- ☐ Cholecystectomy (Gallbladder)
- ☐ Last Colonoscopy Date _____
- ☐ Inguinal Hernia Repair

Genitourinary
- ☐ Artificial Urinary Sphincter
- ☐ Cystectomy (bladder removal)
- ☐ Kidney Stone Surgery
  - ☐ ESWL (shock wave lithotripsy)
  - ☐ Stent
  - ☐ Ureteroscopy (through the bladder)
  - ☐ PCNL (incision in the back)
- ☐ Nephrectomy (kidney removal)
  - ☐ Partial (part of kidney)
  - ☐ Radical (entire kidney)
- ☐ Orchiectomy (testicle removal)
- ☐ Penile Prosthesis
- ☐ Prostate Biopsy
- ☐ Prostate Radiation
  - ☐ Brachytherapy (seeds)
  - ☐ External beam therapy
- ☐ Radical Prostatectomy (prostate removal)
- ☐ TURP (enlarged prostate)
- ☐ Other: _____

Gynecology
- ☐ Cystocele Repair (dropped bladder)
- ☐ Hysterectomy with Abdominal Incision
- ☐ Hysterectomy with Vaginal Incision
- ☐ Ovary Removal (one or both)
- ☐ Rectocele Repair (dropped rectum)
- ☐ Tubal Ligation
- ☐ Incontinence Surgery (sling)

- ☐ Cataract Surgery
- ☐ Nasal Surgery
- ☐ Thyroid Surgery
- ☐ Tonsillectomy

Musculoskeletal
- ☐ Amputation of _____
- ☐ Back Surgery
- ☐ Cervical Spine (Neck) Surgery
- ☐ Hip Replacement
- ☐ Knee Surgery
- ☐ Shoulder Surgery

Respiratory
- ☐ Lung Surgery

Skin
- ☐ Melanoma
- ☐ Other Skin Cancer

Other Surgeries Not Listed
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Have you been instructed by a physician to use special antibiotics before medical procedures because you have a serious heart valve condition or rheumatic fever. This does not include arthritic joints including knee and hips.

If so, PLEASE list the condition: _____

Have you received the flu vaccination this flu season? YES NO When? _____

Have you received the pneumonia vaccine? YES NO When? _____

Family History: Mark if any of your relatives have had any of these conditions

☐ Bladder cancer: father mother brother sister

☐ Kidney Stones: father mother brother sister

☐ Kidney Cancer: father mother brother sister

☐ Kidney Disease: father mother brother sister

☐ Prostate Cancer: father brother grandfather uncle

Have you or a family member had a severe reaction to anesthesia (malignant hyperthermia)? YES NO

Social History:

Marital Status: _____ # of children: _____

Do you use illicit drugs? YES NO

Occupation (If retired, list prior occupation): _____

Do you drink alcohol? YES NO If yes, how much? _____

Do you use tobacco? YES NO If yes, what type? Cigarettes Smokeless Tobacco (chew)

If yes, what number of packs per day? _____

Have you quit smoking? YES NO If yes, when did you stop? _____

Women Only:

Last menstrual period: _____

Number of pregnancies: _____

Number of babies delivered: _____

What are you currently using for birth control? _____

Tennessee Valley Urology Center P.C.
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Tennessee Valley Urology Center, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Tennessee Valley Urology Center, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures. The notice is available to you at the front desk.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Tennessee Valley Urology Center, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tennessee Valley Urology center, P.C. Privacy Officer at 400 Berywood Trail, NW Suite B, Cleveland, TN 37312.

With this consent, Tennessee Valley Urology Center, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, other account balance issues, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Tennessee Valley Urology Center, P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Tennessee Valley Urology Center, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to TENNESSEE VALLEY UROLOGY CENTER, P.C.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, TENNESSEE VALLEY UROLOGY CENTER, P.C. may decline to provide treatment to me.

I may be contacted in the following manner (check all that applies):

Home Telephone

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call-back number only

Written Communication

- ☐ Ok to mail to my home address
- ☐ Ok to mail to my work/office address
- ☐ Ok to fax to this number

Work Telephone

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back number only

Mobile Telephone

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back number only

Patients Name: _____ **Date:** _____

Please initial by each statement and sign at the acknowledgement at the bottom.

_____**Financial Agreement and Authorization for Treatment:** I authorize treatment by Tennessee Valley Urology Center and agree to pay all fees for such charges. I agree to pay promptly and according to the arrangements set by both me and this office. I understand that if a payment arrangement is not previously agreed upon, that all co-insurance, deductibles, and co-pays are due at the time of service. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims unless agreed by both me and this office. In the event this account is turned over for collection, I agree to pay collection and attorney fees.

_____**Assignment of Benefits:** I authorize the release of any medical information necessary to process any and all claims on my behalf. I request payment of any medical benefits including Medicare, Medicaid, Commercial, Workers Comp, Medigap or any other type of insurance benefits be made to the physicians or suppliers for services given. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____**Release of Medical Records:** I authorize the release of all or part of my medical information to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, inpatient, and outpatient facilities. I authorize the use of a fax machine to transmit any or all of my medical records pertaining to my medical care for treatment or insurance reimbursement.

_____**Non-Covered Services:** Your insurance company may not cover a service that YOUR doctor feels is essential to the diagnosis and treatment of your condition. This includes services such as laboratory tests, x-rays, and procedures, etc. The insurance company may deem these procedures as not medically necessary and refuse payment. It is important that we inform that our physician may order tests or perform procedures that may not be covered under your insurance plan and, therefore, you the patient, would be responsible for such charges. You have the right to refuse any service that is not covered by your insurance.

_____**Medical Appointment Cancellation/No Show Policy:** I have read the cancellation/no show policy and understand and agree that should I need to cancel my appointment; I will do so within 24 hours of the appointment time.

_____**Patient Confidentiality:** Due to patient confidentiality, we are unable to relay any information regarding your healthcare to anyone but YOU which includes spouse if they are not listed below. Therefore, when a question arises regarding your appointments, billing, test results, or medical advice in general, we will only respond to you unless we are given prior permission to give information out to other people as indicated below.

You have my permission to discuss any information held in my medical record to:

Name	**Relationship**
_____	_____
_____	_____

Medical Records Access: Your medical records are available to you on our patient portal. Your unique email address is required for access. All of your lab results will be sent to the portal for you to view. Please provide your **Email Address** to set up access:
_____

Text Opt In: Please provide your cell phone number so that we can text important messages to you. The first text you receive will ask you to opt in to text messaging. **Cell Phone Number**: _____

By signing below, I acknowledge that I have read, understood, and agree to the above statements. I have been given the opportunity to ask any questions regarding any of the above statements that I do not understand.

Patient's Primary Care Physician_____

Patient's Name **Date of Birth**

Patient/Guardian Signature **Today's Date**