DESERT MOUNTAIN UROLOGY

Name:_____ **Date**:_____

Primary Care Doctor _____

Why are you seeing the doctor today? _____

Current MEDICATIONS (Or attach medication list)

Medication name:

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES: _____

PHARMACY _____ **ADDRESS or CROSS STREETS** _____

SOCIAL HISTORY

Marital Status: Married Single Divorced Widowed

Occupation _____ Retired _____

Tobacco use _____Never smoked _____ Current smoker _____Former smoker

Recreational drugs ____ none If yes, please list _____

Alcohol _____ drinks/day _____ former abuse _____ Socially _____ Never

PRIOR SURGERY/PROCEDURES

_____

_____

PAST MEDICAL HISTORY (circle)

High blood pressure
Diabetes
Coronary Artery Disease (heart)
Heart Attack
Atrial arrythmia
Blood clot (DVT or PE)
Liver disease
Kidney Disease/ failure
Fibromyalgia
Asthma/ COPD
Diverticulosis/ Diverticulitis

Prior Radiation Treatment

Other _____

PATIENT INFORMATION

Please Print. All information will be confidential

Patient Name_____ Today's Date _____

SSN:	☐ Male ☐ Female
Email	Birthdate
Race, ethnicity Preferred Language	☐ Single ☐ Married ☐ Divorced ☐ Widowed
Home Address	City, State, ZIP
Home Phone	Cell Phone
Emergency Contact	Emergency contact Phone
Employer	Work Phone
Primary Care Physician	Preferred Pharmacy

Insurance Information

Name of insured:	
Relationship to Patient:	
Birthdate of insured:	SSN:
Insurance Company:	Insurance Phone #
Insurance ID #:	Group #
Copay / Deductible:	

Secondary Insurance

Name of Insured:	
Relationship to patient:	
Birthdate of insured:	SSN:
Insurance Company:	Insurance Phone #
Insurance ID #	Group #
Copay / Deducible:	

Authorization & Release

I authorize the release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize my insurance to be billed and benefits paid directly to the doctor. ***I understand that I am financially responsible for any balance whether or not covered and/or paid by my insurance.*** **All copays, deductibles and/or estimated costs are due at the time of service. Please be aware that your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If your insurance company does not pay your claim in a timely manner, the balance will be your responsibility.**

X_____ Date _____

(Patient signature or legal representative)