Alexandria Urology Associates, LLP

Date:_____ 1201 North Bolton Ave. Suite C, Alexandria, LA 71301

Primary(Family) Care Doctor: _____Phone#:_____

Referring Doctor : (who sent you to us ?)_____ Phone#:_____

Patient Name:_____ Birthdate:_____ / _____ / _____ Age :_____

Mailing Address: _____ City:_____ State :_____ Zip:_____

Home phone # (_____)_____Cell phone # (_____)_____ Work # (_____)_____

SS #_____ Marital Status : M / S / W / D Gender: Male / Female

Email address:_____ Disabled: Yes / No

Employer:_____ Retired: Yes / No Student: Yes / No

Race (circle one): Caucasian Hispanic African American Other:_____

Ethnicity (circle one): Non-Hispanic Hispanic Other:_____

Language (circle one): English Spanish Sign Language Other:_____

Spouse Name:_____ Spouse phone # (_____)_____

Emergency Contact:_____ Relationship:_____ Phone # (_____)_____

PHARMACY :_____ LOCATION :_____ PHONE :_____

INSURANCE INFORMATION

Primary Insurance :_____

Secondary Insurance:_____

Other Insurance :_____

- **If spouse is the primary holder of your insurance :**

Spouse Birthdate: _____ / _____ / _____ Spouse SS #_____

*PLEASE COMPLETE REVERSE SIDE OF THIS FORM

URO center
ALEXANDRIA UROLOGY ASSOCIATES

Alexandria Urology Associates, LLP – Review of Symptoms

Name: _____ Date_____

Do you now or have you had any problems related to the following organ systems? Circle Yes or No

General:

Fever	Y	N
Chills	Y	N
Weight Loss	Y	N
Weight Gain	Y	N

Gastrointestinal:

Abdomen Pain	Y	N
Nausea-Vomiting	Y	N
Heartburn	Y	N
Blood in Stool	Y	N
Constipation	Y	N

Respiratory:

Short of Breath	Y	N
Home Oxygen	Y	N
Blood in Sputum	Y	N
Cough	Y	N

Hematologic/Lymphatic:

Bleeding Disorder	Y	N
Swollen Glands	Y	N
Anemia	Y	N

Eyes:

Blurry Vision	Y	N
Decreased Vision	Y	N
Pain	Y	N

Neurological:

Dizziness	Y	N
Weakness	Y	N
Headache	Y	N
Numbness	Y	N

Cardiovascular:

Leg Swelling	Y	N
Chest Pain	Y	N
Irregular heartbeat	Y	N
Palpitations	Y	N

Musculoskeletal:

Joint Swelling	Y	N
Bone Pain	Y	N
Joint Pain	Y	N
Back Pain	Y	N

Endocrine/Renal:

Excessive Thirst	Y	N
Cold Intolerance	Y	N
Hot Flashes	Y	N
Fatigue	Y	N

Ears/Nose/Throat:

Sinus Problems	Y	N
Snoring	Y	N
Difficulty Swallowing	Y	N

Family History: Have any of your blood relatives had any of the following?

Prostate Cancer	Y	N	Kidney Cancer	Y	N	Diabetes	Y	N
Bladder Cancer	Y	N	Kidney Stones	Y	N	Heart Disease	Y	N

Any Living Parents:

Mother Y N Father Y N

In the last 12 months, have you received:

Flu Vaccination	Y	N
Pneumonia Vaccination	Y	N

Habits:

Smoking Y N If yes, Current or Former:_____

How long after you wake do you smoke your first cigarette?_____

Total # years smoking?_____

Packs per Day?_____

Drinking Y N If yes, Socially or Daily?_____

ALLERGIES (please list all medications to which you are allergic): _____

_____

ALL SURGICAL HISTORY (CIRCLE): Hysterectomy, Appendectomy, Gallbladder, Hernia, Heart Bypass, Heart Stents, Other:_____

ALL MEDICAL PROBLEMS (CIRCLE): High Blood Pressure, Diabetes, Heart disease, Cancer, Asthma, Emphysema, Glaucoma, Hypothyroidism, Congestive Heart Failure, Fibromyalgia, Kidney Failure, Other:_____

_____

Current Medications, Dosages/Instructions: _____

_____

_____

Alexandria Urology Associates, LLP

Lance E. Templeton M.D. F.A.C.S. J. Wesley Richey M.D.
Diplomate, American Board of Urology

****Insurance Authorization and Assignment****

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for fees NOT covered by insurance, including but not limited to copays, deductibles, non-covered services, etc. I hereby authorize Alexandria Urology Associates, LLP, to furnish information to insurance carriers concerning my diagnosis and treatment. I hereby assign to the physician(s) all payment for medical services rendered to myself or my dependents.

****I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE****

Signature:_____ Date:_____
REQUIRED

Acknowledgement of Receipt of Privacy Notice (ON BACK)

I have been presented with a copy of Alexandria Urology Associates, LLP'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 the use of my personal information:

_____

Further, I permit a copy of this authorization to be used in the place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment benefits apply.

Signature:_____Date:_____
REQUIRED

Release Form for Individuals Involved in Care of Patient

(This does not include other treating physicians or pharmacists)

I, _____ give Alexandria Urology Associates, LLP permission to speak with
(Patients Name)
the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from Alexandria Urology Associates, LLP. This consent is valid until such time as I provide Alexandria Urology Associates, LLP written revocation of it.

Listing or NOT listing names is at the discretion of the patient.
For Example you may want to list: The name of Spouse, family, or friends.

Name:_____ Relationship: _____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

Signature:_____ Date:_____
(Required)

If not signed by the patient, please indicate relationship to patient.
Relationship_____ Witnessed by:_____

Alexandria Urology Associates, LLP
1201 North Bolton Ave. Suite C Alexandria, LA 71301
Telephone (318) 473-2169 Fax (318) 487-8447

Lance E. Templeton M.D. F.A.C.S
Diplomate, American Board of Urology

J. Wesley Richey M.D.
Diplomate, American Board of Urology

Your information is important and confidential.
Our ethics and policies require that your information be held in strict confidence.

We will use your health information for regular health operations.
We may disclose your health information for our routine operations. These uses are necessary for certain administrative, financial, legal and quality improvement activities that are necessary to run our practice and support the core functions.

For Example:
Health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide and to reduce healthcare costs.

Appointment Reminders:
We may disclose medical information to provide appointment reminders (e.g., contacting you at the phone number you have provided to us and leaving a message as an appointment reminder).

Decedents:
Consistent with applicable law, we may disclose health information to a coroner, medical examiner, or funeral director.

Workers Compensation:
We may disclose health information to the extent authorized by and necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public Health:
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Research:
We may disclose information to researchers when their research has been approved and the researcher has obtained a required waiver from the Institutional Review board/Privacy Board, who has reviewed the research proposal.

Organ Procurement Organizations:
Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of donation and transplant.

As Required by Law:
We may disclose health information as required by law. This may include reporting a crime, responding to a court order, grand jury subpoena, warrant, discover request or other legal process or complying with health oversight activities, such as audits, investigations and inspections, necessary to ensure compliance with government regulations and civil rights laws.

Specialized Government Functions:
We may disclose health information for military and veterans affairs or national security and intelligence activities.

Business Associates:
There are some services provided in our organization through contacts with business associates. Some examples are billing or transaction services we may use. Due to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.

Practice Marketing:
We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you (for example, to notify you of any new tests or services offered).

Food and Drug Administration (FDA):
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs, or replacement.

Personal Representative:
We may use or disclose information to your personal representative (person legally responsible for your care and authorization to act on your behalf in making decisions related to your health care).

To Avert a Serious Threat To Health/Safety:
We may disclose your information when we believe in good faith that this is necessary to prevent a serious threat to your safety or that of another person. This may include cases of abuse, neglect, or domestic violence.

Communication with Family:
Unless you object, health professionals, using their best judgment, may disclose to a family member or close personal friend health relevant to that person's involvement in your care or payment related to your care. We may notify these individuals of your location and general condition.

Disaster Relief:
Unless you object, we may disclose health information about you to an organization assisting in a disaster relief effort.

For all non-routine operations, we will obtain your written authorization before disclosing your personal information. In addition, we take great care to safeguard your information in every way that we can to minimize any incidental disclosures.