Anne Arundel Urology, PA

PLEASE CHECK HERE IF THERE ARE NO CHANGES TO ANY INFORMATION ON THIS PAGE: __________

Last Name	First Name	MI	Birth Date	Age
Address		City	State	Zip Code
Home Phone	Work Phone	Social Security #	Marital Status **M W S SP D**	Gender **M or F**
Cell Phone	Email Address (required for patient portal) **Do you want to receive billing statements via Email? Y N**		Employment Status FT PT RET UNEM	Student Yes No
Emergency Contact Information (Name/Phone Number/Relationship)			Do you have an Advance Directive (Living Will)? Yes _______ No ______	

Is the physician listed below still your Primary Care Provider? **YES** ___________ **NO** ___________
Physician:
Primary Care Physician:

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

Last Name	First Name	MI	Relationship to Patient	
Address		City	State	Zip Code
Home Phone	Work Phone	Social Security #	Birth Date	Gender
Cell Phone		Email Address		

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Name		Insurance Name	
Claims Address		Claims Address	
City, State, Zip	Ins Phone No.	City, State, Zip	Ins Phone No.
Employer Group Ins? Yes ☐ No☐ Employer Name: Employer Address: Employer Phone:		Employer Group Ins? Yes ☐ No☐ Employer Name: Employer Address: Employer Phone:	
Subscribers Name	Gender M ☐ F ☐	Subscribers Name	Gender M ☐ F ☐
Subscribers ID	Group No.	Subscribers ID	Group No.
Subscribers Birth Date & SSN	Effective Date	Subscribers Birth Date & SSN	Effective Date
Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐		Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	

AUTHORIZATION

Our primary responsibility is to help our patients experience good health. Payment for services is expected to be paid at the time of service, including co-payments. If you do not pay your co-pay on the date of service, your appointment may need to be rescheduled.
Our billing office will submit all claims to your insurance carrier. Any outstanding balances are due at the time of first billing.
I authorize the release of medical records or other information necessary to process my claims, as well as payment of medical benefits to Anne Arundel Urology, P.A./Anne Arundel Urological Surgery Center, LLC. I also acknowledge that I am responsible for any missed appointment or cancellation fees incurred.

I, ____, fully understand that I am responsible for payment of services rendered.

Patient Signature ____ Date____________________

Anne Arundel UROLOGY

Patient Name: ______________________________

DOB: ____________________

Referring Physician: ________________ Primary Care Physician: ________________

Pharmacy Name: ____________________ Pharmacy Location: ____________________

The following information is confidential and will not be released to anyone without your authorization.

CHIEF COMPLAINT (What is the main reason for seeing the doctor?):

____

List any other MEDICAL PROBLEMS, including the use of a CPAP machine

1. ______________________ 4. ______________________

2. ______________________ 5. ______________________

3. ______________________ 6. ______________________

No Changes since last year check here ____________________

Number of pregnancies ______________ Number of deliveries ____________________

List all SURGERIES you have had, including heart valve or joint replacement (include month/year if possible)

1. ______________________ 4. ______________________

2. ______________________ 5. ______________________

3. ______________________ 6. ______________________

No Changes since last year check here ______________________________

List all MEDICATIONS you take including dosage and frequency (please include Aspirin if taken daily):

1. ______________________ 6. ______________________

2. ______________________ 7. ______________________

3. ______________________ 8. ______________________

4. ______________________ 9. ______________________

5. ______________________ 10. ______________________

**Do you take antibiotics prior to a dental visit Yes __________ No__________

Please list any ALLERGIES to medications or latex. Please list their names and the reaction (i.e. – rash, hives, etc.):

______________________________ ______________________________

______________________________ ______________________________

FAMILY HISTORY

***Have any members of your family had or have Diabetes, Heart Disease, Respiratory issues, Stroke, or any type of cancer? If yes, please specify:

____

SOCIAL HISTORY

Marital Status: Single _______ Married _______ Widowed _______ Separated _______ Divorced ______

Occupation ______________________________

Do you currently smoke cigarettes/cigars/pipe? NO ______ YES ______ If so, how much?____________________

Did you ever smoke? NO ______ YES ______ If so, when did you quit and how much?__________________

Do you drink alcohol? NO ______ YES ______ How much?______________________________

REVIEW OF SYSTEMS No changes since last year check here ______________________________

Do you have any problems related to the following systems? (Please circle)

GENERAL
Change in energy
Weight gain
Chills
Fever
Change in mobility

SKIN
Itching
Rash
Ulcers
Lesions

HEAD, EYES, EARS, NOSE, & THROAT
Double Vision
Head Injury/Trauma
Visual Loss
Hearing Loss
Ringing in Ears
Nasal Congestion
Hoarseness

RESPIRATORY
Chronic cough
Shortness of Breath
Wheezing
Bloody Sputum
Recent Respiratory Infection
Hay fever
Environmental allergies
Chronic Immune Problems

HEART
Chest pain
Shortness of Breath with Exercise
Palpitations

GASTROINTESTINAL
Abdominal Pain
Tarry stools
Blood in Stool
Constipation
Diarrhea
Nausea
Vomiting
Bloating

URINARY
Burning with Urination
Frequency
Urinary leakage
Waking up to void
Urgency
Unable to void

MUSCULOSKELETAL
Back pain
Decreased range of motion
Joint pain
Joint swelling

NEUROLOGIC
Trouble Walking
Memory loss
Difficulty speaking
Stroke
Seizures

PSYCHIATRIC
Anxiety
Depression
Mood changes

ENDOCRINE
Appetite change
Cold intolerance
Excessive thirst
Heat intolerance
Thyroid problems

HEMATOLOGY
Prolonged Bleeding
Anemia
Easy bruising