

**Beaver  
Valley  
Urology**  
Please Print

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Patient Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Patient Sex (circle)    M    F  
\_\_\_\_\_ Martial Status (circle)    S    M    D    W  
\_\_\_\_\_ Social Security # \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Employer Name \_\_\_\_\_ Employer Phone # \_\_\_\_\_  
Employer Address \_\_\_\_\_

**INSURANCE INFORMATION (Must Be Completed)**

1. Name of PRIMARY Insurance Company _____ Claim Mailing Address _____ _____ Phone # _____ Owner of Policy _____ Date of Birth _____ Phone # _____ Address _____ <input type="checkbox"/> Check Here if Patient is Owner Relationship _____ ID/Policy # _____ Group # _____ Employer _____ *Name of Primary Care Physician _____	2. Name of SECONDARY Insurance Company _____ Claim Mailing Address _____ _____ Phone # _____ Subscriber Name _____ Subscriber Date of Birth _____ Subscriber Phone # _____ Subscriber Address _____ _____ Relationship _____ ID/Policy # _____ Group # _____ Employer _____ Name of Primary Care Physician _____
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**OTHER INFORMATION**

Spouse Name \_\_\_\_\_ \*Name of Referring Doctor \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Phone # \_\_\_\_\_  
In Case of Emergency Contact (not at same address)  
Name \_\_\_\_\_  
Phone \_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# Beaver Valley Urology, LTD

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Assignment and Release

### Authorization for release of information

I authorize the release of any medical information to my insurance carriers concerning my medical treatment necessary to process my claim to Beaver Valley Urology, LTD. I understand that any false claims, statements of documents or concealment of material fact may be prosecuted under applicable federal and state law.

### AUTHORIZATION FOR ASSIGNMENT FO PAYMENTS

I authorize the payment of medical benefits to Beaver Valley Urology, LTD for all services rendered to me. ***I UNDERSTAND THAT I AM REPOSNSIBLE FOR ALL CHARGES INCLUDING CO-PAYMENTS AND/OR CHARGES THAT ARE NOT COVERED BY MY INSURANCE. I UNDERSTAND THAT REFERRALS FOR PARTICIPANTS ARE THE PARTICIPANT'S RESPONSIBILITY. IF NO AUTHORIZATION WAS APPROVED PRIOR TO SERVICES, I WILL ACCEPT FINANCIAL RESPONSIBILITY FOR THE SERVICES RENDERED. THIS PAYMENT WILL BE DUE AT THE TIME OF SERVICE OR WHEN DEMANDED.***

If I have liability for my medical services such as auto, worker's compensation, accident, etc, ***I UNDERSTAND THAT IA M ULTIMATELY LIABLE FOR SERVICES RENDERED TO ME AND I AGGREE TO PAY DIRECTLY TO BEAVER VALLEY UROLOGY SHOULD THE CLAIM WITH MY INSURANCE CARRIER AND/OR POLICY HOLDER BE DENIED OR CHALLENGED.***

### CONSENT TO TREATMENT

I authorize treatment to myself by Beaver Valley Urology, LTD including the employees therein.

\_\_\_\_\_  
(Signature of patient or authorized person/guardian)

\_\_\_\_\_  
(date)

# Patient History Form

Today's Date \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M \_\_\_\_\_

What is the main reason for your visit today? \_\_\_\_\_

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## Past Medical History:

List all medical conditions current and prior (ex. high blood pressure, heart disease, diabetes, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## Past Surgical History:

List all surgical procedures that you have had done in your lifetime.

\_\_\_\_\_  
\_\_\_\_\_

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## Social History:

Do you smoke? Y N Have you previously? \_\_\_\_\_

Do you drink alcoholic beverages? Y N \_\_\_\_\_

Do you drink caffeine? Y N \_\_\_\_\_

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## Family History:

List any remarkable medical history (ex. heart disease, diabetes, cancer)

Mother \_\_\_\_\_ Maternal Grandmother \_\_\_\_\_

Paternal Grandmother \_\_\_\_\_

Father \_\_\_\_\_ Paternal Grandfather \_\_\_\_\_

Maternal Grandfather \_\_\_\_\_

Brother \_\_\_\_\_

Sister \_\_\_\_\_

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## Allergies:

List any allergies to medications \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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## Current medications:

List all medications including over the counter drugs and vitamins \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Review of Systems

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

Please explain any Yes answers in space provided

## Constitutional Symptoms

Fever Y N  
 Chills Y N  
 Headache Y N  
 Other \_\_\_\_\_

## Eyes

Blurred vision Y N  
 Double vision Y N  
 Pain Y N  
 Other \_\_\_\_\_

## Allergic/Immunologic

Hay Fever Y N  
 Drug allergies Y N  
 Other \_\_\_\_\_

## Neurological

Tremors Y N  
 Dizzy spells Y N  
 Numbness/tingling Y N  
 Other \_\_\_\_\_

## Endocrine

Excessive thirst Y N  
 Too hot/cold Y N  
 Tired/sluggish Y N  
 Other \_\_\_\_\_

## Gastrointestinal

Abdominal pain Y N  
 Nausea/vomiting Y N  
 Indigestion/heartburn Y N  
 Other \_\_\_\_\_

## Cardiovascular

Chest pain Y N  
 Varicose veins Y N  
 High blood pressure Y N  
 Other \_\_\_\_\_

## Integumentary

Skin rash Y N  
 Boils Y N  
 Persistent itch Y N  
 Other \_\_\_\_\_

## Musculoskeletal

Joint pain Y N  
 Neck pain Y N  
 Back pain Y N  
 Other \_\_\_\_\_

## Ear/Nose/Throat/Mouth

Ear infection Y N  
 Sore throat Y N  
 Sinus problems Y N  
 Other \_\_\_\_\_

## Genitourinary

Urine retention Y N  
 Painful urination Y N  
 Urinary frequency Y N  
 Other \_\_\_\_\_

## Respiratory

Wheezing Y N  
 Frequent cough Y N  
 Shortness of breath Y N  
 Other \_\_\_\_\_

## Hematologic/Lymphatic

Swollen glands Y N  
 Blood clotting problem Y N  
 Other \_\_\_\_\_

## Psychologic

Are you generally satisfied with your life? Y N  
 Do you feel severely depressed? Y N  
 Have you considered suicide? Y N  
 Other \_\_\_\_\_

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_