UROLOGY GROUP OF ATHENS

Phone: (706) 543-6261 Fax: (706) 543-7060
John Blankenship, M.D.
Stephanie Johnson, NP-C **Tina Hale, NP-C**

Dear New Patient,

We would like to take this opportunity to welcome you as a patient. It is our desire to make your visit smooth and efficient. We thank you in advance for your cooperation.

To facilitate your appointment, we ask that you please take a few moments and complete the enclosed forms. The doctor cannot see you until this information has been filled out and entered into our EMR system. **If** you have **not** completed the forms prior to your visit, **please come 30 minutes before your scheduled time.**

You may return the completed forms by fax (706)543-7060, US Mail to the Athens office, or scan and e-mail to **UGofA.frontdesk@gmail.com**. Please note if you choose to e-mail, we **do not** have a secure e-mail connection.

We need you to bring the following to your appointment:

- Completed Forms
- Insurance Cards
- Driver's License or Picture ID
- Insurance Co Pay
- List of Medications and Allergies **(Bring updated list to every appointment)**
- CD disk of x-rays or labs if performed, relating to your current problem

If you have been referred to our practice and your insurance requires a referral from your PCP, please contact your PCP and make sure that they get the proper paperwork to us. Please check with us in advance to ensure it has been received. **Failure to have a referral upon arrival will result in rescheduling your appointment.**

Please also note that any payments and copays not covered by your insurance carrier will be due at or before time of service.

Thank you,
Urology Group of Athens

Main Office:
195 King Ave
Athens, GA 30606

Royston Office: (Piedmont Royston Bldg)
930 Franklin Spring St
Royston, GA 30662

UROLOGY GROUP OF ATHENS

195 King Avenue
Athens, GA 30606
PHONE: (706) 543-6261 **FAX:** (706) 543-7060
EMAIL: Admin@urologygroupofathens.com
WEBSITE: urologygroupofathens.com

PATIENT INFORMATION

ALL INFORMATION IS MANDATORY

Patient Name (First, Middle, Last) ______________________________ Race__________

Date of Birth _____/_____/______ Social Security _______-______-________ DL#______________ Male___ Female____

Mailing Address______________________________City________________________ State________ ZIP__________

Home Number ______-______-______ Work Number ______-______-_______ Cell Number _______-________-_______

Preferred Phone # ______________________ E-Mail____

Disabled: Yes ____ No ____ If yes, why: ____________________________________ Marital Status ______________

Nursing Home/Assisted Living: Yes___ No ___ Where: ____
(If yes, circle which one)

Primary Care Doctor__________________________ Preferred Pharmacy __________________ Location__________

Employer Name/Address________________________________ City ________________ State ________ZIP __________

PARENT OR RESPONSIBLE PARTY INFORMATION

Name (First, Middle, Last) ____

Relationship to Patient________________________________ Phone Number ______-______-______

Address ___________________________________ City______________________ State________ ZIP ____________

Insurance Information

Primary Insurance ____________________________________Policy Number__________________________________

Benefits Phone Number _____________________ Policy Holder Name__________________________________

Secondary Insurance __________________________________Policy Number__________________________________

Benefits Phone Number _____________________ Policy Holder Name__________________________________

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled, including major medical, Medicare, Medicaid, private insurance and any other health plan to Urology Group of Athens. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

PAYMENT IS EXPECTED AT TIME OF SERVICE

$25.00 charge for any FMLA/DISABILITY Paperwork to be Completed

$35.00 Returned Check Charge

IF SENT TO A COLLECTION AGENCY, A 40% RECOVERY FEE WILL BE APPLIED

YOU MAY BE CHARGED $50 FOR OFFICE APPOINTMENT NO-SHOWS.

Signature____ **Date**__________________

PATIENT MEDICATION LIST

Patient Name____

Medication Allergies

Please list the name of the medication that you are allergic to, and the type of reaction that you had.

Name of Medication ______________________________ Reaction __________________

Name of Medication ______________________________ Reaction __________________

Name of Medication ______________________________ Reaction __________________

Name of Medication ______________________________ Reaction __________________

Medications

Please list all prescribed, and over-the-counter medications that you take currently, and as needed. List the date medicine was prescribed to you, and the name, strength, and directions of the medications. If you are unsure of any of the information, please bring your medicine bottles with you to your appointment.

EXAMPLE:

Medication Name	Dosage	Directions
Aspirin	*81 mg*	*Once daily*

Medication Name	Dosage	Directions

Name____ **Date of Birth**____________________

History of Present Illness

What is the reason for your visit? ____

How long have you had this problem? ____

Where is your problem located? ____

On a scale of 0-10, how would you rate the severity of your problem? (0=not bad, 10=very bad) _______________

Past Medical History

Have you ever had any of the following?

- Acute Infections . . . . Yes No
- Arthritis . . . . Yes No
- Cancer . . . . Yes No
  - Type__________________
- Seizures . . . . .Yes No
- Coronary Artery Disease. . Yes No
- Diabetes . . . . Yes No
- Hepatitis . . . . Yes No

Hypertension . . . . .Yes No
Kidney Stones . . . . Yes No
Latex Allergy . . . . Yes No
Pacemaker . . . . Yes No
Thyroid Disease . . . . Yes No
Chronic Kidney Disease. . . . . . . .Yes No
Other____________________________
____

Cardiologist Name: ____

Pulmonologist Name: ____

List All Prior Surgeries/Recent Hospitalizations

Surgery:________________________________ Hospital ____________________ Date__________

Surgery:________________________________ Hospital ____________________ Date__________

Surgery:________________________________ Hospital ____________________ Date__________

Surgery:________________________________ Hospital ____________________ Date__________

Surgery:________________________________ Hospital ____________________ Date__________

Social History

Marital Status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed
Alcohol Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Tobacco Use ☐ Never ☐ Previously but quit/Former ☐ Currently: packs/day____________________
Non-prescription drug use ☐ Never ☐ Former: Type ___________ ☐ Current: Type_______________

Family Medical History

	Age	Disease/Disorder Type	Cause of death
Father	______	____________________	______________
Mother	______	____________________	______________
Siblings	______	____________________	______________
	______	____________________	______________

REVIEW OF SYSTEM

CONSTITUTIONAL

Fever .... No Yes
Chills .... No Yes
Fatigue .... No Yes

EYES

Change in Vision .... No Yes
Blurred Vision .... No Yes

HENT

Sore Throat .... No Yes
Nasal Congestion .... No Yes

BREAST

Lumps .... No Yes
Swelling .... No Yes
Tenderness .... No Yes
Nipple Discharge .... No Yes

CARDIOVASCULAR

Chest Pains .... No Yes
Cardiac Murmur .... No Yes
Irregular Heartbeat .... No Yes

RESPIRATORY

Wheezing .... No Yes
Shortness of Breath .... No Yes
Painful Respiration .... No Yes

GASTROINTESTINAL

Loss of Appetite .... No Yes
Nausea .... No Yes
Vomiting .... No Yes
Diarrhea .... No Yes
Constipation .... No Yes
Blood in Stool .... No Yes

ALLERGIC – IMMUNOLOGIC

Sinus Allergy Symptom .... No Yes
Allergic Dermatitis .... No Yes
Frequent Illness .... No Yes

GENITO-URINARY

Urgency .... No Yes
Frequency of Urination .... No Yes
Painful Urination (Dysuria) .... No Yes
Frequent Urination at Night (Nocturia) .... No Yes
Incontinence .... No Yes
Difficulty Voiding .... No Yes
Decreased Stream .... No Yes
Post Void Dribbling .... No Yes
Decreased Sex Drive .... No Yes
Excessive Thrist .... No Yes
Vaginal Discharge .... No Yes
Impotence .... No Yes
Scrotal Pain .... No Yes

NEUROLOGICAL

Numbness or Tingling Sensation .... No Yes
Incoordination .... No Yes
Headaches .... No Yes
Seizures .... No Yes

MUSCULOSKELETAL

Bone Pain .... No Yes
Back Pain .... No Yes
Joint Pain .... No Yes
Muscle Pain .... No Yes

ENDOCRINE

Excessive Urination .... No Yes
Cold Intolerance .... No Yes
Heat Intolerance .... No Yes
Weight Gain .... No Yes
Weight Loss .... No Yes

HEMATOLOGY/LYMPHATIC

Easy Bleeding .... No Yes
Easy Bruising .... No Yes
Lymph Enlargement .... No Yes

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John Blankenship, MD

Records Transfer Request

I ____, do hereby authorize the release of
(Print Full Name)
my medical records or copies of such and request that they be transferred to Urology Group of Athens.

Date of Birth __________/__________/____________________________

Social Security Number _______________-____________-______________

Address -____

City_________________________ State __________ ZIP _______________

Phone Number ____

Signature____
(Patient, Parent, or Guardian)

****

OFFICE USE ONLY

TO:____
Doctor/Hospital

ADDRESS:____

CITY:_____________________________ STATE: ________ ZIP:_________________________

PHONE NUMBER:_____________________ FAX NUMBER:______________________________

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E-Prescribing Consent

E-Prescribing software sends your prescriptions over the internet to your pharmacy safe and securely, by applying the same technology used by credit card companies. This helps protect the privacy of your personal information while allowing your provider to access important data such as drug interactions and prescription history.

I agree that Urology Group of Athens may request and use my prescription medication history from other healthcare providers or pharmacy benefit payers for treatment purposes.

Appointment Cancellation Policy

We do our best to accurately schedule our clinic to accommodate patient's needs, doctor's schedules, equipment schedules, and our nurse's schedules. As a result, last minute cancellations and/or no-shows are very disruptive to our clinic and schedules. Therefore, we ask that if you need to cancel or reschedule your appointment that you do this as soon as possible.

Effective November 1, 2012, if you cancel an office visit less than 24 hours before the appointment time then you will be charged a $50 late cancellation/no-show fee.

If you cancel a surgery, procedure, or a cystoscopy (in the surgery center or in the hospital) less than 48 hours before scheduled time then you will be charged a $100 late cancellation/no-show fee.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Name (Print) ____

Signature ____

Date ______________________________

HIPAA Privacy Consent

Urology Group of Athens

______________________________ ______________

Patient Name **Date of Birth**

Our Notice of Privacy Practice (NPP) states we may disclose your protected health information (PHI) to others who are involved in your care, such as spouse, children, parents, caregivers, or others.

A) List anyone you would authorize us to share or discuss your PHI. This could include medical treatment, diagnosis, appointments, billing, or releasing of records.

Name: ______________________ Relationship: ______________ Number______________

Name: ______________________ Relationship: ______________ Number______________

Name: ______________________ Relationship: ______________ Number______________

Name: ______________________ Relationship: ______________ Number______________

Name: ______________________ Relationship: ______________ Number______________

B) If you do not wish for us to disclose your PHI to anyone, please initial here. ____________

Please list phone numbers we can leave a message on:

Home Cell Other ______________________________
(Circle One)

Home Cell Other ______________________________
(Circle One)

Your right to limit uses of PHI for treatment, payment or operations (TPO):
Under the terms of the NPP, you can ask Urology Group of Athens to limit how your personal health information is used or disclosed to carry out treatment, payment, or operations. Only the Urology Group of Athens Privacy Officer is authorized to agree to your request. If you wish to RESTRICT the use/disclosure for TPO, please make your request in writing to the Privacy Officer, Urology Group of Athens. In your written request, you must tell us 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply, for example: disclosures to your adult children. If you have any questions regarding this please contact our office at (706) 543-6261.

You may change or revoke this consent at any time by completing a new form.

______________________________ ______________

Patient Signature/Guardian Date

____

Relationship if other than Patient