STARKVILLE UROLOGY, PLLC

SARAH RENTROP, MD   W. JORDAN WINDHAM, MD

PATIENT INFORMATION

Patient's Name (First) ____________________(Middle)____________________(Last)____________________________

Mailing Address ________________________________ City ______________________ State ________ Zip __________

SSN ______________________________ Cell Phone ________________________ Home Phone ____________________

Sex __________ Marital Status ____________________ Date of Birth _____________________ Age _______________

Employer ____ Work Phone ____________________________

Emergency Contact ____ Phone Number __________________________

Primary Physician ____ Phone Number __________________________

Pharmacy ____ City ___________________________________

SPOUSE/PARENT/GUARDIAN INFORMATION

Name____ Date of Birth _____________________

Address ____ City ______________________ State ________ Zip __________

SSN ______________________________ Cell Phone ________________________ Home Phone ____________________

Employer ____ Work Phone ____________________________

INSURANCE INFORMATION

Primary Insurance ______________________________ Name of Insured _____________________________________

ID # ______________________________ Relationship _____________________ Insured DOB ____________________

Secondary Insurance ____________________________ Name of Insured _____________________________________

ID # ______________________________ Relationship _____________________ Insured DOB ____________________

Please allow receptionist to copy all insurance cards and picture ID after completion of the paperwork

Signature of Patient or Legal Representative ____ **Date** _______________

STARKVILLE UROLOGY, PLLC

PATIENT INFORMATION

Date ________________

Name ____ **Age** ______________ **DOB** ______________

How did you hear about us? ____

____

Allergies (medication allergies, x-ray dye allergies, etc) ____________________________

____

____

Surgeries ____

____

____

Do you have an implanted device? (Example: pacemaker, defibrillator, interstim, etc) YES NO

Do you take Nitroglycerin for chest pain? YES NO

Do you have a medical condition that requires prophylactic antibiotic treatment prior to any procedures being performed (artificial joint, mitral valve prolapse or heart valve)? If yes, please explain ____________________________

____

PAST MEDICAL HISTORY

Autoimmune Disorder	Yes	No	Gastric reflux/ulcers	Yes	No
Arthritis	Yes	No	Eye disorders/glaucoma	Yes	No
Artificial joint/joint replacement	Yes	No	Liver disease	Yes	No
Bleeding disorder/blood transfusion	Yes	No	High blood pressure	Yes	No
Personal cancer history ______________			High cholesterol	Yes	No
Lung disease:	Oxygen	CPAP	Kidney disease/kidney failure	Yes	No
Diabetes	Yes	No	Dialysis	Yes	No
Skin disorders	Yes	No	Ear, nose, throat problems	Yes	No
Heart disease, heart attack, stroke, congestive heart failure	Yes	No	Seizures	Yes	No
			Thyroid disease	Yes	No
Psychiatric illness	Yes	No			

FAMILY HISTORY

Diabetes	Yes	No	Bladder Cancer	Yes	No
Heart disease	Yes	No	Kidney Cancer	Yes	No
Lung disorders	Yes	No	Prostate Cancer	Yes	No
Renal disease/failure	Yes	No	Penile or Testicular Cancer	Yes	No
Kidney stones	Yes	No	Other Cancer	Yes	No

SOCIAL HISTORY

Current Smoker?	Yes	No	Prior Smoker?	Yes	No
Packs per day? ______________			Year Quit: ______________		
How many years? ______________					
Do you drink alcohol?	Yes	No	How often? ______________		
Illegal Drugs? ______________					

Occupation or former occupation: ____

Patient Signature ________________________________ **Date** ______________

Physician Signature ________________________________ **Date** ______________

STARKVILLE UROLOGY, PLLC

MEDICATION RECONCILIATION SHEET

PATIENT NAME ____ **DOB** ____________________________

Medication Name	Dose	Frequency	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial

STARKVILLE UROLOGY
PATIENT CONSENT AND AUTHORIZATION FORM

Patient Name: ____

Date of Birth: ____

Address: ____

____

Phone #: ____

Consent to Treat:
By my initials hereto and signature below, I voluntarily seek and consent to medical treatment at Starkville Urology. This consent includes examination and treatment by the physicians, nurses and other health care professionals at Starkville Urology. I also consent to any medical procedures, CT scans, Urodynamics, Ultrasound, laboratory tests and/or other health care services ordered by Starkville Urology. I understand that I may refuse specific treatments or procedures by informing a health care professional of such refusal. ____________ **(initial)**

Medical Records:
Medical records cannot be sent to your primary care physician or referring provider without written permission from you. By my initials hereto and signature below, I authorize Starkville Urology to disclose my patient information and medical record to the physician(s) or provider(s) listed on my patient registration form. I understand that I may revoke this authorization, except to the extent that action has already been taken, in writing at any time by sending written revocation of authorization to Starkville Urology. ____________ **(initial)**

Test Results:
Test results cannot be left on your voicemail or answering machine or discussed with another family member, even your spouse, without your written permission. By my initials hereto and signature below, I authorize that Starkville Urology may leave information regarding test results with the following individual(s): ____________ **(initial)**

Name of Person: ________________________________ Relationship to Patient: _______________

Name of Person: ________________________________ Relationship to Patient: _______________

Confirmation of Appointments:
As a courtesy to you, we do call prior to the day of your appointment to confirm the time and date of your appointment. This information cannot be left on your voicemail or answering machine or related to someone else without written permission. By my initials hereto and signature below, I authorize Starkville Urology to leave appointment reminder information by voicemail, answering machine or with the person who may answer my phone number. ____________ **(initial)**

Discussion of Your Account/Payment Responsibility:
We cannot discuss your bill with anyone without written permission, including your spouse or any other family member, unless they have a power of attorney on file. By my initials hereto and signature below, I give Starkville Urology permission to discuss billing information with the following individual(s): ____________ **(initial)**

Name of Person: ________________________________ Relationship to Patient: _______________

Name of Person: ________________________________ Relationship to Patient: _______________

Acknowledgement of Notice of Privacy Practices:
By my initials hereto and signature below, I verify that I have been given the HIPAA Notice of Privacy Practices, which provides me with the information of how my Protected Health Information (PHI) is used. ____________ **(initial)**

Assignment and Release:
By my initials hereto and signature below, I assign directly to Starkville Urology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I agree that in the event of non-payment for services provided, I accept full and complete responsibility for the balance due, collection costs, court costs, as well as any attorney fees should legal action become necessary. I authorize the use of my signature on all insurance submissions. ____________ **(initial)**

Starkville Urology may use my health care information and may disclose such information to the named insurance company or companies (as listed on the patient registration form) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. ____________ **(initial)**

Patient (or Guardian) Signature: ____ Date: ___________________

Printed Name of Patient (or Guardian): ____