Columbus Urology Group

Patient Information

Name

Mailing Address

Home Phone Cell Phone Male ( ) Female ( ) Married ( ) Single ( )

Age Date of Birth Social Security Number

Primary Doctor Personal Email Address

FOR PATIENTS UNDER THE AGE OF 18, PLEASE LIST:

Parent/Guardian(s) Name Date of Birth Social Security Number

EMPLOYMENT INFORMATION: (If patient is under 18 list parent/guardian's employer)

Name Phone

Address

EMERGENCY CONTACT INFORMATION:

Name and Relationship Phone

MEDICAL INSURANCE INFORMATION:

Primary Insurance Policy Number Group

Policy Holder's Name Date of Birth Social Security #

Secondary Insurance Policy Number Group

Policy Holder's Name Date of Birth Social Security #

Patient's Name: _____

Height: _____ Weight:_____

Patient's Medical History: Circle any that apply)

Diabetes
Cancer
Arthritis
Ulcer
Renal Failure
Stones
Recurrent Urinary Tract Infections
Recurrent Prostate Infections
Stroke
Asthma
COPD
Blood Clot
Pulmonary Embolism
Heart Attack
Congestive Heart Failure
Arrhythmia
High Blood Pressure
Diverticulitis
Depression
Hepatitis
Anemia
Thyroid Disease
Other _____

FAMILY Medical History: (DO NOT INCLUDE YOURSELF)

Cancer
If so, what type of cancer: _____?

Prostate Cancer
Kidney Stones
Heart Disease
Diabetes
Stroke
High Blood Pressure

Please list surgeries that you have had in the past:

_____
_____
_____

Social History: Circle any that apply

Single Married Divorced Widowed

Smoker Y or N
How many daily?
Former Smoker Y or N

Drink Alcohol Y or N
Illicit Drug Use Y or N

Coffee Y or N
How many cups daily?
Sodas/Tea Y or N
How much daily?

Please list any Drug Allergies:_____

_____

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(ROBERT HOWLAND MD, JOSHUA GRIFFIN MD, BENJAMIN WOODSON MD, PAUL BARRETT CFNP)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your records to anyone unless you direct us to do so or unless the law authorizes us to do so. Our notice of patient privacy describes in detail how your health information may be used and how you can access your information.

PURPOSE: To provide patient care
INFORMATION TO BE DISCLOSED: All Urology Group medical information/records including labs and other referred services.
PERSONS AUTHORIZED TO USE OR DISCLOSE: The staff of Urology Group.
EXPIRATION: Indefinite unless revoked or terminated by the patient or patient's representative.
RIGHT TO TERMINATE: You may revoke or terminate this disclosure by submitting a written revocation to the front office of Urology Group.

PERSONS TO WHO MY MEDICAL INFORMATION MAY BE DISCLOSED TO:

Person's Name & Relationship/Organization:_____

Person's Name & Relationship/Organization: _____

Person's Name & Relationship/Organization:_____

Person's Name & Relationship/Organization: _____

BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES AND PERMISSION TO DISCLOSE MY MEDICAL INFORMATION TO THE ABOVE MENTIONED PARTIES.

_____ _____

Name of Patient Patient's Signature or Legal Representative

_____

Date

Columbus Urology Group
321 Hospital Drive
Columbus, MS 39705

Phone: (662) 327-2921
Fax: (662) 328-6858

Dear _____,

Please complete all pages prior to your appointment. Be sure to bring the new patient paperwork, your insurance cards, driver's license or photo I.D., and the medications that you are currently taking to your appointment (please do not mail information to us). If you have any questions, please call the number above.

We look forward to seeing you on _____at _____.