

Columbus Urology

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: _____

Columbus Urology

(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: _____

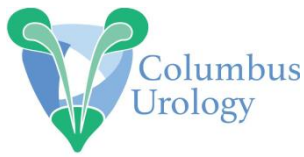
Person's Name & Relationship/Organization: _____

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



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 _____.

Columbus Office
321 Hospital Drive
Columbus, MS 39705
Phone: 662-327-2921
Fax: 662-328-6858



Starkville Office
976 Highway 12 East
Starkville, MS 39759
Phone: 662-498-1811
Fax: 662-328-6858

