DENTON UROLOGY
2401 West Oak Street Ste. #102
Denton, Texas 76201
Phone: 940-387-2241 Fax: 940-380-1374

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

DENTON UROLOGY
2401 West Oak Street Ste. #102
Denton, Texas 76201
Phone: 940-387-2241 Fax: 940-380-1374

INSTRUCTIONS FOR RELEASING PROTECTED HEALTH INFORMATION TEST RESULTS, ETC.

Please check "Yes" or "No"

OK TO GIVE TO MY SPOUSE **YES____NO____**

OK TO GIVE TO MY PARENT/CHILD **YES____NO____**

OK TO LEAVE ON ANSWERING MACHINE/VOICE MAIL **YES____NO____**

EMERGENCY CONTACT_____ **YES____NO____**
PHONE NUMBER _____

SPEAK ONLY TO ME
(If this box is checked "yes"-all other lines must be check "no") **YES____NO____**

SIGNATURE_____
(If patient is a minor, guardian must sign)

PATIENT'S NAME (PRINTED)_____

DATE_____

PATIENT INFORMATION FORM

Name_____

Address_____

City/State_____ **Zip Code**_____

Home Ph (_____)_____ **Cell Ph (_____)**_____

Work Ph (_____)_____ **Email** _____

Date of Birth_____ **Preferred Contact: Home Cell Work**

Gender: ☐ Male ☐ Female **Martial Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐ Caucasian ☐ Black ☐ Asian ☐ American Indian
☐ Hispanic ☐ Pacific Islander ☐ Other

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Other

Social Security#_____ **Family Doctor**_____

Employer Name/Retired/Disabled_____

Pharmacy Name and Location_____

Do you have any known drug allergies? _____

GUARDIAN/RESPONSIBLE PARTY/INSURED'S INFORMATION

Name_____

Address/Phone# (if different) _____

Date of Birth _____**Social Security#**_____ ☐ **Male** ☐ **Female**

Employer/Business Name _____**Work Phone**_____

I consent to treatment necessary for the care of the patient indicated on this form. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Denton Urology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as any original. I understand that I am financially responsible for all charges, whether or not paid by the said insurance. Authorization is hereby granted to release information as may be necessary to process and complete my claim.
I verify that the above demographic information is correct and that I have supplied a current insurance card for the filing of medical services rendered to me. I understand that failure to notify Denton Urology of any insurance coverage changes could result in the financial obligation to rest fully on myself regardless of any contract between the insurance company and Denton Urology.

Signed_____**Date**_____

How did you hear about our practice?

☐ **Friend** ☐ **Patient** ☐ **Physician** ☐ **Yellow Pages** ☐ **Internet** ☐ **Other**_____

PATIENT HISTORY FORM

Patient's Name:_____ **Date:**_____

Past Medical, Family & Social History

List all serious illnesses in your immediate family. (Example: diabetes. tuberculosis, breast cancer, heart disease, etc.,)

Mother _____ Sister _____ Grandmother _____

Father _____ Brother _____ Grand father _____

List any personal past illness and/or surgeries and when they occurred. Illness or Surgery Date

_____ _____

_____

_____ _____

Do you smoke? ☐ Yes ☐ No
If yes, how much? _____
Were you a former smoker? ☐ Yes ☐ No

Do you drink? ☐ Yes ☐ No
If yes, how much? _____
Do you have a history of non-prescription/illegal drug use? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No
If yes, how much? _____

Age 65 or Older Y or N

Review of Systems

Do you now or have you had any ongoing problems related to the following systems? Circle **Y**es or **N**o.

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 problem	Y	N

Other _____

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Incontinence	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 _____

YOUR PRIMARY CARE PHYSICIAN IS: _____

Physician Signature: _____ Date: _____

MEDICATION LIST

Patient Name: **Date of Birth:**

Drug Name	Strength	Dosage					

Please list any medication allergies: _____

_____