

# Las Vegas Urology

ADULT AND PEDIATRIC UROLOGY

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Male/Female

Parent or Legal Guardian (if minor): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*Referred By: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Nearest Relative Not Residing with You: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

## Insurance Information

Name of Primary Insurance Carrier: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

ALL identifying numbers on card: \_\_\_\_\_

Secondary Insurance (husband's or wife's): \_\_\_\_\_

ALL identifying numbers: \_\_\_\_\_

**THIS FORM MUST BE COMPLETED (and if taken returned within 7 days) IN ORDER FOR US TO BILL YOUR INSURANCE. FAILURE TO DO SO WILL MEAN THAT YOU ARE RESPONSIBLE FOR ALL INSURANCE BILLING!**

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Family History:**

Serious Illness/Cause of Death	Mother's Family	Father's Family	Age
Heart disease			
Hypertension			
Stroke			
Cancer			
Diabetes			
Kidney disease			
Prostate disease			
Bladder disease			
Other			

**Current Medications:** Please list all medications you are currently taking (include all non-prescriptive drugs and birth control pills).

Name of Medication	Amount	Frequency
Medication Allergies: (Please list) _____		

**Urologic History**

**Are you experiencing...**

- Any burning with urination?  Yes  No
- Any visible blood with urine?  Yes  No
- Loss of control of your urine?  Yes  No
- Any unusual skin problems or persistent sores?  Yes  No
- Any previous infections?  Yes  No
- Serious sexual difficulties or change in sexual performance?  Yes  No

- Any unusual frequency or change in pattern of urination?  Yes  No  
Explain: \_\_\_\_\_
- Average number of times you urinate at night? \_\_\_\_\_
- Generally are you able to completely empty your bladder?  Yes  No

**Women:**

- Date of last menstrual period \_\_\_\_\_
- Date of last pap smear \_\_\_\_\_
- Age at onset of menstrual period \_\_\_\_\_
- Do you have any unusual problems with your menstrual periods?  Yes  No
- # of live births \_\_\_\_\_ Miscarriages \_\_\_\_\_
- Any Complications: \_\_\_\_\_
- Do you examine your breasts each month?  Yes  No
- Do you have any unusual vaginal odor, discharge, or itching?  Yes  No

**Men:**

- Do you examine your testicles regularly?  Yes  No
- Any previous genital infections?  Yes  No

**What is your present Urologic complaint:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Nurse signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician signature: \_\_\_\_\_ Time: \_\_\_\_\_