UROLOGY ASSOCIATES OF DELAWARE
TRUSTED KNOWLEDGE | PROVEN EXPERIENCE

Medical History

THIS FORM IS TO BE COMPLETED BY ALL "NEW" PATIENTS AND THOSE WHO HAVE NOT VISITED OUR OFFICE FOR 3 YEARS.

Patient Name _____ Date of Birth ___/___/___ Age _____

Date of 1st Visit ___/___/___ Referring Dr. _____ Family Dr. _____

Please describe in your own words the reason(s) for which you are being seen in our office today: _____

PLEASE INDICATE BY CHECKING THE APPROPRIATE BOXES IF YOU HAVE EVER HAD ANY OF THE PROBLEMS BELOW

If you answer yes to any of the conditions below, please provide details.

Condition	Yes	No	Details	Condition	Yes	No	Details
Asthma/COPD/Emphysema	☐	☐		Bleeding Disorder	☐	☐	
Heart Attack/Heart Disease	☐	☐		Kidney Stones	☐	☐	
Positive TB Test	☐	☐		Kidney Infection	☐	☐	
High Blood Pressure	☐	☐		Blood In Urine	☐	☐	
Heart Attack	☐	☐		Unable to Urinate	☐	☐	
Stroke	☐	☐		Pain Upon Urination	☐	☐	
Epilepsy or Convulsions	☐	☐		Cancer	☐	☐	
STD/AIDS/HIV	☐	☐		Heart Disease	☐	☐	
Diabetes/High Blood Sugar	☐	☐		Vision Problems	☐	☐	
Thyroid Problems	☐	☐		Muscle Back Pain	☐	☐	
Hepatitis	☐	☐		Artificial Joints	☐	☐	
Stomach Ulcers/Gerd	☐	☐		Headaches/Migraine	☐	☐	
Artificial Heart Valve	☐	☐		Other	☐	☐	
Heart Murmur/MVP	☐	☐		Other	☐	☐	

PLEASE ANSWER THE QUESTIONS BELOW

- Has anyone in your immediate family had cancer, diabetes, heart disease, other? Yes ☐ No ☐
- History of surgeries (please include dates) _____
- Do you smoke? Yes-Amount _____ No _____ Quit When? _____
- Do you drink alcohol? Yes-Amount _____ No _____ Quit When? _____
- Do you drink caffeinated drinks? Yes-Amount _____ No _____ Quit When? _____

Please list all current medications you are now using. (Use back if necessary)

Are you allergic to any medications? If yes, please list: _____

Patient Signature _____ Date ___/___/___

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Patient Information Form

********Please Note: This form is to be completed in its entirety every year or when changes occur********

NAME AND ADDRESS

Patient Last Name: _____ First Name: _____ M.I.: _____ Sex: F or M

Date of Birth: ____/____/____ Age _____ Soc. Security: _____-_____-_____ Marital Status: ☐ M ☐ S ☐ D ☐ W

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Work: (_____)_____-_____ Cell: (_____)_____-_____

Email: _____ Best Way to Contact: ☐ Home Phone ☐ Work ☐ Cell

EMPLOYER

Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Emergency Contact: _____ Relationship: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Work: (_____)_____-_____ Cell: (_____)_____-_____

PRIMARY DOCTOR

Primary Doctor: _____ Phone: (_____)_____-_____

Referring Doctor: _____ Phone: (_____)_____-_____

PRIMARY INSURANCE

Primary Health Insurance: _____ I.D./Policy: _____ Group #: _____

Subscriber Name: _____ Date of Birth: ____/____/____ Eff. Date: ____/____/____

SECONDARY INSURANCE

Secondary Health Insurance: _____ I.D./Policy: _____ Group #: _____

Subscriber Name: _____ Date of Birth: ____/____/____ Eff. Date: ____/____/____

PHARMACY

Pharmacy: _____

Location: _____ Phone: (_____)_____-_____

SIGNATURE

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AUTHORIZE MY INSURANCE COMPANY(S) TO PAY DIRECTLY TO UROLOGY ASSOCIATES OF DOVER. I UNDERSTAND AND AGREE THAT ANY UNPAID BALANCE NOT COVERED WILL BE PAID BY ME.

Signature: _____ Date: ____/____/____

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Financial Policy

Urology Associates of Delaware requires all patients to meet their financial responsibilities. If you are covered by a health insurance plan(s) it is up to you to know the terms of your contract as it relates to co-payments, deductibles and co-insurance.

You are required to pay for any co-payments not covered by your health plan on the day of your scheduled visit. We accept cash, checks and credit cards and money orders.

If you have a financial hardship you may qualify for a payment plan for any services not covered by your health plan. You will need to meet with one of our financial staff to determine if you qualify. Please note that Co-payments are not eligible for a payment plan.

Our policy is to send you a for bill services rendered by Urology Associates of Delaware approximately every 28 days. If we do not receive payment as we are entitled, you will be placed immediately with a collection agency and possibly discharged from our practice. Please note that you will be charged a collection handling fee.

We do not accept any partial payments received as a negotiated agreement.

Most patients meet their financial obligations for which we are very grateful. Otherwise, we would not be able to provide the high level of medical care that our patients expect and deserve.

Patients without insurance (Self-pay) are required to pay for all services on the day of their appointment. A payment plan may be used to pay for ***subsequent*** visits to Urology Associates of Delaware. Patients who can pay their balances in full will receive a 25 % discount. Only patients already ***established*** with this office and who ***do not*** have health insurance (I.E., self-pay) qualify for a discount.

A 20% late fee will be added to any account that has been turned over to an outside collection agency.

There is a $35 charge of all returned checks.

There is a $35 charge for declined credit cards taken by phone.

I have read and understand my responsibilities for payment as outlined above.

_____ Date: ____/____/____

Patient Signature