Hixson Urology

Ross Cohn, MD
Angela Ogle, APN-C

Patient Information

Date: _____

Patient Name: _____ SSN:_____
Last First Middle
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____ Age: _____
Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

Employer Name: _____ Employer Address: _____
Position: _____ Work Phone: _____ - _____ - _____
Student Status: ( ) None ( ) Full-Time ( ) Part-Time

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widow
Spouse's Name: _____ Spouse's SSN: _____
Spouse's Employer: _____ Spouse's Date of Birth: _____
Spouse's Employer Address: _____ Spouse's Work Phone: _____-_____-_____

Primary Care Physician: _____ Referring Physician: _____

Nearest Relative (not living in household): _____
Address: _____ Home Phone: _____ - _____ - _____
City: _____ State: _____ Zip: _____ Work Phone: _____ - _____ - _____
Relationship to Patient: _____ Cell Phone: _____ - _____ - _____

Primary Insurance Information
Policyholder: _____
Date of Birth: _____
Insurance Company Name:_____
Street Address: _____
City: _____State: ___ Zip: _____
Group Name or Number:_____
Insured's ID#: _____
Effective Date: _____

Secondary Insurance Information
Policyholder: _____
Date of Birth: _____
Insurance Company Name:_____
Street Address: _____
City: _____ State: ____ Zip:_____
Group Name or Number: _____
Insured's ID#: _____
Effective Date: _____

I authorize the release of medical information to insurance company. I agree to be responsible for my account and any collection fees incurred in obtaining payment.

Your Signature: _____

Today's Date: _____

Memorial Hixson Professional Building
2051 Hamill Road, Suite 201
Hixson, TN 37343
Phone - 423-877-2844 Fax - 423-877-1959

Patient Privacy Policy

Acknowledgment Form

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information (PHI). In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communications or that a communication of PHI to be made by alternative means, such as sending correspondence to the individual's home. If you have any objections to this form, please ask to speak with our HIPPA compliance officer in person or by phone at (423) 877-2844.

Patient Name: _____

____ Home Telephone
- ____ OK to leave message with detailed information
- ____ Leave message with call back number only

____ Written Communication
- ____ OK to mail to my home
- ____ OK to mail to my work
- ____ OK to fax to this number
- ____ Other: _____

_____

____ Work Telephone
- ____ OK to leave message with detailed information
- ____ Leave message with call back number only

<u>Authorization to release Protected Health Information to individuals/family members</u>

____ I authorize Hixson Urology to verbally, or with written consent, release any or all of my PHI to the following individuals:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

____ I do not authorize Hixson Urology to release any of my PHI to any individuals/family members except as set forth above.

Patient Signature: _____ Date: _____

Witness: _____

New Patient Package
Notification and Releases

We want to welcome you to our practice. We want to make your experience with every aspect of our service meet or exceed your expectations. If you have any questions, concerns, comments or suggestions for improvement in our services, please do not hesitate to speak with any of our staff or physicians. Listed below are several notices that outline certain responsibilities of ours and yours. Please read them carefully and sign where indicated that you have read each statement.

General Consent for Treatment

We look forward to treating you as a patient. However, we need your permission for our physicians to examine you, provide treatments and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

I give general consent to be treated by _____ M.D.

Patient: _____ Date: _____

Financial Policy/Assignment of Benefits

As a courtesy to our patients, the practice will accept assignment for most commercial insurance programs and Medicare. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment of our services. If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. In addition, if the fees for our services are not paid, we may turn the account over to a collection agency. If an account is turned over for collection, their fees, attorney's fees and court cost will be added to the account balance. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

I acknowledge responsibility for payment of fees for services provided by the practice and authorize the practice to release any medical information, if necessary, to my insurance company.

Patient/Guarantor: _____ Date: _____

Privacy Policy

New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. If you would like a copy of our privacy policies, please ask any of our staff and we will be happy to give it to you. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits or for medical management issues. If anyone else helps us with our internal operations, we will require them to keep any patient information they may see confidential. All other releases of information have to be specifically authorized by you. If you ask us to account for these releases of information, we will provide that to you. You may also request and receive a copy of your medical record and ask questions about its content. We will keep your record as long as you are a patient of the practice and seven years after your last visit. Unless you tell us otherwise, when we contact you by phone and you are not available, we will leave a message with the person who answered or we will leave a voicemail message, if available.

Patient: _____ Date: _____

Hixson Urology, PC

2051 Hamill Road Suite 201, Hixson, TN 37343

Phone: (423) 877-2844 Fax: (423) 877-1959

Ross Cohn, MD Angie Ogle, NP

This form officially provides Hixson Urology, P.C. permission to review pertinent patient data, view images and/or reports from Memorial Hospital and/or Memorial Hospital Hixson.

This form officially gives Hixson Urology, P.C. permission to discuss imaging and laboratory data with Memorial Hospital and/or Memorial Hospital Hixson and/or providers at either Memorial Hospital campus.

Print Name: _____

Sign Name: _____

Date: _____

FORMS POLICY

There will be a $20 fee to fill out FMLA forms, and $25 for disability forms to be completed by our office.

This fee is per form and must be paid in full before the forms will be completed.

Please allow 7-10 business days for the forms to be finished.

By signing this form, I understand the above policy and agree to pay the fee if I have forms to be filled out.

Print Name: _____

Sign Name: _____

Date: _____

Date_____

Name_____ DOB _____ Race_____

Referring Doctor _____ Family Doctor_____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

What improves or worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain?_____

Is the problem/pain continuous or does it come and go? _____

Describe the pain (sharp, dull, etc.)_____

Have you tried any medicine/treatment for this problem/pain? _____

If you are disabled, what is your disability? _____

Have you had a flu shot? ❒ YES ❒ NO

Have you had a pneumonia vaccine? ❒ YES ❒ NO

Have you had a colonoscopy in the last 9 years? ❒ YES ❒ NO Date_____

Height: _____ Weight:_____

ALLERGIES: Please list ALL types (drug, seasonal, pets, environmental, foods) _____

_____

_____

Pharmacy Name and location _____ Phone Number_____

Please list all medications including over the counter and vitamins (or attach a list):

Past Medical History

Please CIRCLE if you <u>have</u> or <u>have had</u> any of the following:

CARDIOVASCULAR
Anemia
Arrhythmia
Atrial Fibrillation
Bleeding Disorder
Cerebrovascular Disease
Chest Pain/Angina
Congestive Heart Failure
Deep Vein Thrombosis
Enlarged Heart
Heart Attack
Heart Disease
Heart Murmur
High Blood Pressure
Leukemia
Mitral Valve Prolapse
Rheumatic Fever
Sickle Cell Anemia
Varicose Veins

ENDOCRINE/METABOLIC
Diabetes Type 1 or 2
Goiter
Gout
Hyperthyroidism
Hypothyroidism

GENERAL
(HIV) AIDS
Allergies
Exposure to Chemicals
Hepatitis A B or C
High Cholesterol
Infectious Disease
Lipid Disorder
Malaise
Obesity

GI
Gallstones
Constipation
Colon Cancer
Colon Condition
Crohn's Disease
Diarrhea
Diverticulitis
Diverticulosis
GERD
Hemorrhoids
Hernia
Irritable Bowel Syndrome
Liver Disease
Pancreatitis
Pancreatic Cancer
Rectal Cancer
Rectal Fissure
Stomach Cancer
Stomach Ulcer

GU
Bladder Cancer
Bladder Outlet Obstruction
Bladder Stone
Blood in Urine
Elevated PSA
Erectile Dysfunction
Interstitial Cystitis
Kidney Cancer
Kidney Disease
Kidney Stones
Libido Decreased
Orchitis
Penile Discharge
Prostate Cancer
Renal Failure
Testicular Cancer
Transplant Recipient
Ureteral Cancer
Undescended Testicle
Urinary Tract Infection
Venereal Disease

GYN/OB
Breast Cancer
Breast Disease
Cervical Cancer
Endometriosis
Fibrocystic Breast Disease
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Cancer
Uterine Fibroids

HEENT
Brain Cancer
Brain Tumor
Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Laryngeal Cancer
Meniere's
Mumps
Sinusitis
Tinnitis
Vertigo

MUSCULOSKELETAL
Arthritis
Back Pain
Carpal Tunnel Syndrome
Fibromyalgia
Mortons Neuroma

NEUROLOGICAL/ PSYCHOLOGICAL
ADD
ADHD
Alcoholism
Alzheimer's Disease
Anxiety
Bi-polar Disorder
Chronic Fatigue Syndrome
Dementia
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Neuropathy
Parkinson's
Polio
Schizophrenia
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt

RESPIRATORY
Asthma
Bronchitis
COPD
Emphysema
Lung Cancer
Lung Disease
Pneumonia
Pulmonary Embolism
Sleep Apnea
Tuberculosis

TUMORS
Lymphoma
Melanoma
Sarcoidosis

OTHER:_____

_____

Surgical History

Please CIRCLE if you <u>have had</u> any of the following surgeries and date of surgery:

CARDIOVASCULAR
Carotid Artery Surgery
Heart Surgery
Heart Transplant
Pacemaker Insertion
Vein Stripping

GENERAL
Brain Surgery
Laminectomy
Lymphatic Node Dissection
Parathyroidectomy
Pilondial Cyst Incision
Skin Grafting

GI
Appendectomy
Bowel Resection
Colonoscopy
Colon Resection
EGD / Dilation Esophagus
Fissurectomy
Gallbladder removed
Hemorrhoidectomy
Hernia Repair
Ileostomy
Laparoscopy
Liver Surgery
Splenectomy
Stomach Surgery

GU
Bladder Surgery
Brachytherapy
Circumcision
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy-Stent
Cysto-TUR Fulguration
Durasphere
Epididymectomy
Hydrocelectomy
Ileal Conduit
Interstim
Lithotripsy (ESWL)
Meatotomy
Needle Biopsy Prostate
Nephrectomy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Surgery
Pyeloplasty
Radical Prostatectomy
Renal Transplant
Spermatocelectomy
TUMT Prostate
TUNA Prostate
TURBT
TUR Prostate
Ureteroscopy
Variocelectomy
Vasectomy

GYN/OB
Bladder Tack
Breast Surgery
C Section
Hysterectomy
Lumpectomy of Breast
Oophorectomy
Vaginal Sling

HEENT
Ear Surgery
Eye Surgery
Facial Surgery
Mastoid Surgery
Nasal Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery

MUSCULOSKELETAL
Amputation
Back Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Hip Surgery
Knee Surgery
Leg Surgery
Rotator Cuff Surgery
Shoulder Surgery

RESPIRATORY
Lung Surgery
Trachea Surgery

SKIN
Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

OTHER:_____

_____

FAMILY HISTORY

Please indicate which family member has/had any of the following: (Mother, Father, Brother, Sister, Grandmother, Grandfather, Uncle, Aunt)

Arthritis _____
Bedwetting _____
Bladder Cancer _____
Cancer (site unknown) _____
Crohn's Disease _____
Depression _____
Diabetes _____
Gout _____
Heart Attack _____
High Blood Pressure _____
Kidney Cancer _____
Kidney Disease _____
Leukemia _____
Malignant Melanoma _____
Multiple Sclerosis _____
Laryngeal Cancer _____
Pancreatic Cancer _____
Prostate Cancer _____
Stroke _____
Thyroid Disease _____
Tuberculosis _____
Other _____
_____

Social History

Current Marital Status: Please indicate number of years.

Single____ Married____ Separated____ Divorced____ Widowed____
Life Partner____ Common Law Spouse____

Alcohol Consumption: Circle One

_____Never _____Not Anymore

_____Yes: Occasional/Social Number of drinks ____ day month week year

Tobacco per day:

____None _____Yes #____packs/day _____Cigarettes/day _____Smokeless Tobacco
If you previously stopped, when?_____

Recreational drugs: _____None If yes, please list:_____

Caffeinated beverages: None or # drinks a day _____

Review of Systems

CONSTITUTIONAL
Appetite Changes
Aches and Pains
Chills
Easy Bruising
Eating Disorder
Fever
Fatigue
Generalized Weakness
Insomnia
Night Sweats
Sleep Apnea
Swollen Glands
Weight Changes

EYES
Blind
Blurred Vision
Double Vision
Glaucoma
Pain
Worsening Eyesight

ALLERGIC/IMMUNOLOGIC
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

NEUROLOGICAL
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness / Tingling
Stroke
Speech Problems
Tremors

ENDOCRINE
Diabetes
Excessive Thirst
Pituitary Disease
Thyroid Disease
Tired / Sluggish
Too Hot / Cold

GASTROINTESTINAL
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowels
Constipation
Diarrhea
Gas
Hemorrhoids
Indigestion / Heartburn
Nausea / Vomiting
Rectal Bleeding
Tarry Stool

CARDIOVASCULAR
Chest Pain / Angina
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse
Palpitation

SKIN
Acne
Boils
Changing Moles
Persistent Itch
Skin Rash

MUSCULOSKELETAL
Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain / Stiffness

EAR/NOSE/THROAT
Ear Infection
Sinus Problem
Sore Throat

GENITOURINARY
Back Pain
Bedwetting
Blood in Urine
Burning on Urination
Dribbling
Erection Problems
Flank Pain
Kidney Failure
Kidney Infections
Kidney Stones
Leak after Voiding
Night time Urination
Nocturnal Enuresis
Not Emptying
Painful Ejaculation
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine Retention
Urologic Concern
Vaginal Bleeding
Discharge
Weak Stream

RESPIRATORY
Asthma
Emphysema-Bronchitis
Frequent Cough
Pneumonia
Shortness of Breath
Tuberculosis
Wheezing

HEMATOLOGICAL/LYMPHATIC
Swollen Glands
Blood Clotting Problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell

PSYCHOLOGICAL
Anxiety
Depressed
Generally satisfied with life