



# UroCare

Practice Limited to Urology  
and Urological Surgery

James W. Faulkner, III, M.D.  
David A. Guthman, M.D., F.A.C.S.  
Jerrod H. Seckler, M.D., F.A.C.S.  
Helen C. Ahn, M.D.

**Patient Information: Please print and complete all entries.**

Legal Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Complete Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Sex: M or F

Social Security # \_\_\_\_\_

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

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

E-Mail: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

May we call you at work? Yes \_\_\_ No \_\_\_

May we leave detailed messages on voicemail? Yes \_\_\_ No \_\_\_

May we discuss your medical information with family members? Yes \_\_\_ No \_\_\_

If yes, Name \_\_\_\_\_ Phone \_\_\_\_\_

Additional Names \_\_\_\_\_ Phone \_\_\_\_\_

Referring/Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Next of Kin and Emergency Contact Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

I certify that to the best of my knowledge, this information is correct and true. I will notify this office in case of any changes to my health or any of the above information. I hereby authorize the release of all pertinent medical information to insurance carriers for the purpose of payment.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## MEDICAL HISTORY

## FORM 2A

Patient Name: \_\_\_\_\_

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

### PLEASE FILL OUT ALL SECTIONS

We need to know your past medical history to best understand how we can help you.

What reason are you here to see the doctor today?

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

Prior and current illnesses or serious injuries  None

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

Prior surgeries or hospitalizations  None

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

Current Medications – Doses and schedule  None

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

Allergies and reactions to drugs, foods, or other  None

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

## FAMILY MEDICAL HISTORY

Check all that apply:  None

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> CVA/Stroke                               | <input type="checkbox"/> Emphysema                                      | <input type="checkbox"/> Hypertension    |
| <input type="checkbox"/> Colon Cancer                | <input type="checkbox"/> Chronic Obstructive<br>Pulmonary Disease | <input type="checkbox"/> Heart Disease                                  | <input type="checkbox"/> Kidney Stones   |
| <input type="checkbox"/> Congestive Heart<br>Failure | <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Hypercholesterolemia<br>(Elevated Cholesterol) | <input type="checkbox"/> Prostate Cancer |





## MEDICAL HISTORY

## FORM 2B

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Please circle "Yes" or "No" to all questions and describe your current medical condition.

<p><b>Constitutional Symptoms</b></p> <p>Fever.....NO YES Weakness.....NO YES Weight Loss.....NO YES</p> <p><b>Integumentary (breast/skin)</b></p> <p>Skin Infections.....NO YES Rash.....NO YES</p> <p style="text-align: center;"><b>Eyes</b></p> <p>Loss of vision ___Right ___Left.....NO YES Blurry Vision ___Right ___Left.....NO YES</p> <p style="text-align: center;"><b>Ears, Nose, Mouth, Throat</b></p> <p><b>Head:</b> Headaches.....NO YES</p> <p><b>Ears:</b> Dizziness.....NO YES Congestion.....NO YES Ringing in the ears.....NO YES</p> <p><b>Nose:</b> Nosebleeds.....NO YES</p> <p><b>Mouth/Throat:</b> Difficulty swallowing.....NO YES Sore throat.....NO YES</p> <p style="text-align: center;"><b>Cardiovascular</b></p> <p>Swelling of feet, ankles or hands.....NO YES Shortness of breath.....NO YES Racing heart beats.....NO YES Chest pain at rest.....NO YES Chest pain at exercise.....NO YES</p> <p style="text-align: center;"><b>Respiratory</b></p> <p>Chronic or frequent cough.....NO YES Wheezing.....NO YES</p> <p style="text-align: center;"><b>Gastrointestinal</b></p> <p>Heartburn.....NO YES Abdominal pain.....NO YES Diarrhea.....NO YES Vomiting.....NO YES Nausea.....NO YES Constipation.....NO YES</p>	<p><b>Genitourinary</b></p> <p>Frequent Urination.....NO YES Urgent need to urinate.....NO YES Pain with urination.....NO YES Nighttime urination.....NO YES Number of times per night..... Difficulty starting urinary stream.....NO YES Leakage or Dribbling.....NO YES Reduced flow.....NO YES Blood in urine.....NO YES Straining to urinate.....NO YES Sexual difficulty.....NO YES <b>Female – irregular periods.....NO YES</b></p> <p><b>Musculoskeletal</b></p> <p>Joint pain.....NO YES Muscle weakness.....NO YES Leg cramps.....NO YES</p> <p><b>Neurological</b></p> <p>Confusion.....NO YES Headache.....NO YES Fainting.....NO YES Seizures or convulsion.....NO YES Memory Loss/Dementia.....NO YES</p> <p><b>Psychiatric</b></p> <p>Anxiety.....NO YES Insomnia.....NO YES</p> <p><b>Endocrine</b></p> <p>Excessive thirst.....NO YES Low-level of activity/tired.....NO YES</p> <p><b>Hematologic</b></p> <p>Excessive bleeding with dental work.....NO YES Bruising.....NO YES</p> <p><b>Allergic/Immunologic</b></p> <p>Frequent Skin rashes.....NO YES Frequent infections.....NO YES</p> <p>Patient Signature _____</p> <p>Physician Signature _____</p>
---	---



**PLEASE REVIEW DOCUMENT**  
**THIS IS OUR FINANCIAL POLICY FOR WHICH YOU ARE RESPONSIBLE.**

**PATIENT FINANCIAL RESPONSIBILITY**

1. If insurance card is unavailable, payment is required in full at time of service.
2. Payment can be made with cash, check, Visa, MasterCard, Discover, and debit cards.
3. ***The bill for services rendered is your responsibility, the patient.*** We participate in many managed care plans, will file and make attempt to collect our allowable fees, however, if they do not pay in a timely fashion ***it is ultimately your responsibility*** and we will expect payment from you.
4. If you are covered by an insurance plan, you must provide:
  - a. Co-payment at time of service.
  - b. Valid insurance card and verification at or before date of service.

**BILLING POLICY**

1. There will be a \$25.00 service charge for any returned check.
2. All outstanding balances beyond 45 days could be assessed a finance charge of 18% APR.
3. Every bill generated after 30 days will be assessed a \$10.00 rebilling charge.
4. After 90 days of inactivity, accounts will be turned over to a collection agency at which time your outstanding balance will be assessed up to a 25% collection charge.
5. **There will be a \$25.00 charge for no call/no show appointments.**
6. **You will be charged \$75.00 if you do not show up or cancel your appointment within 24 hours of the scheduled procedure.**

For patients who are underage, non-emergent treatment will be denied unless the adult accompanying the minor accepts responsibility.

I understand and agree, regardless of my insurance status, I am ultimately responsible for my co-pay, deductible, and any non-covered charges. I have read all of the information on this sheet and acknowledge my financial responsibilities.

Name \_\_\_\_\_ Date \_\_\_\_\_