Millennium Physicians

TEXAS REGIONAL UROLOGY

NEW PATIENT MEDICAL QUESTIONNAIRE

GENERAL INFORMATION

PATIENT NAME: _____ DOB: _____ SEX: MALE or FEMALE

HEIGHT: _____ FT _____ IN WEIGHT: _____ POUNDS RACE: _____

SOCIAL SECURITY #: _____-_____-_____ INSURANCE: _____ INS ID: _____

ADDRESS: _____

PHONE #: _____ CELL WORK HOME ALT. PHONE #: _____ CELL WORK HOME

REFERRING PROVIDER: _____ PRIMARY CARE PHYSICIAN: _____

MARITAL STATUS: _____MARRED _____SINGLE _____DIVORCED _____WIDOW

CHIEF COMPLAINT/REASON FOR VISIT

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

ARE YOU EXPERIENCING ANY PAIN? YES or NO, IF YES WHERE IS THE PAIN LOCATED? _____

IF YOU MARKED YES, PLEASE INDICATE ON A SCALE OF 1 - 10 WITH 10 BEING THE HIGHEST THE LEVEL OF YOUR PAIN: _____

MEDICATIONS PLEASE LIST ALL PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS THAT YOU TAKE ON A REGULAR BASIS (IF YOU ALREADY HAVE A LEGIBLE LIST PLEASE GIVE TO THE FRONT DESK)

MEDICATION NAME	DOSE (EX: 50MG)	FREQUENCY	REASON FOR TAKING

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES or NO, IF YES PLEASE LIST: _____

ARE YOU ALLERGIC TO INRAVENOUS CONTRAST: YES or NO, IF YES LIST YOUR REACTION: _____

ANY OTHER ALLERGIES? YES or NO, IF YES PLEASE LIST: _____

PHARMACY INFORMATION

FOR OUR PATIENTS CONVIENENCE WE HAVE MILLENNIUM PHYSICIANS PHARMACY IN OUR KINGWOOD/WOODLANDS LOCATIONS, THEY ALSO DELIVER TO THE OFFICE YOU ARE CURRENTLY SEEING YOUR PHYSICIAN AT. HOWEVER, YOU CAN CHOOSE ANY PHARMACY OF YOUR CHOICE.

_____ MILLENNIUM PHYSICIANS PHARMACY, THE WOODLANDS 281-298-1129

_____ MILLENNIUM PHYSICIANS PHARMACY, KINGWOOD 281-312-8585

_____ OTHER: _____ PHONE NUMBER: _____

Texas Regional Urology

Millennium Physicians

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SOCIAL HISTORY

1. DO YOU OR HAVE YOU EVER USED TOBACCO PRODUCTS? YES or NO, IF YES PLEASE COMPLETE THE FOLLOWING QUESTIONS, IF NO SKIP TO QUESTION 2.

SELECT ALL THAT APPLY: _____ CURRENT SMOKER, EVERY DAY _____CURRENT SMOKER, SOME DAYS

_____ LIGHT TOBACCO SMOKE _____ HEAVY TOBACCO SMOKER _____ FORMER SMOKER

SELECT ALL THAT APPLY: _____ CIGARETTES _____ PER DAY _____CIGARS _____PER DAY

_____ SMOKELESS _____ PER DAY _____ PIPES _____PER DAY

2. HAVE YOU HAD EXPOSURE TO SECOND HAND SMOKE? YES or NO
3. DO YOU DRINK ALCOHOLIC BEVERAGES? YES or NO, IF YES HOW OFTEN? _____

FAMILY MEDICAL HISTORY

PLEASE LIST IF ANY OF YOUR FAMILY MEMBERS BELOW HAVE OR HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL CONDITIONS: BLEEDING/CLOTTING DISORDERS, CANCER (IF KNOWN TYPE, PLEASE LIST), DIABETES, HEART DISEASE, HYPERTENSION, LEUKEMIA, LYMPHOMA, HEART ATTACK, STROKE.... ETC

FAMILY MEMBER NAME/RELATIONSHIP	AGE	ALIVE/DECEASED	MEDICAL CONDITION

PAST MEDICAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOING TESTS WITHIN THE LAST 6 MONTHS?

_____ PETSCAN IF YES, WHEN/WHERE: _____

_____ CT SCAN IF YES, WHEN/WHERE: _____

_____ ULTRASOUND IF YES, WHEN/WHERE: _____

_____ OTHER WHEN/WHERE: _____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 6 MONTHS: YES or NO

IF YES, WHEN/WHERE AND REASON: _____

PLEASE LIST ANY PRIOR SURGERIES AND/OR ANY ADDITIONAL INFORMATION THAT YOU WOULD LIKE THE PHYSICIAN TO KNOW: _____

_____

Millennium Physicians

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NEW PATIENT MEDICAL QUESTIONNAIRE

REVIEW OF SYMPTOMS

CHECK THE SYMPTOMS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR. CHECK ALL THAT APPLY.

GENERAL

_____ CHILLS
_____ DEPRESSION/NERVOUSNESS
_____ EXCESSIVE WEIGHT GAIN
_____ FEVER
_____ HEADACHE
_____ NUMBNESS

CARDIOVASCULAR

_____ CHEST PAIN
_____ HIGH/LOW BLOOD PRESSURE
_____ IRREGULAR HEART BEAT
_____ POOR CIRCULATION
_____ SHORTNESS OF BREATH
_____ SWELLING IN ANKLES
_____ VARICOSE VEINS

SKIN

_____ ANY CHRONIC RASHES OR ERUPTIONS
_____ CHANGE IN MOLES
_____ HIVES
_____ ITCHING
_____ IRREGULAR SCARS
_____ POOR HEALING OF LESIONS/WOUNDS
_____ POOR HEALING OF FOOT LESIONS

EYE, EAR, NOSE, THROAT

_____ BLEEDING GUMS
_____ BLURRED VISON
_____ CROSSED EYES
_____ DIFFICULTY SWALLOWING
_____ DOUBLE VISION
_____ EARACHE OR DISCHARGE
_____ HAY FEVER
_____ HOARSENESS
_____ LOSS OF HEARING
_____ NOSEBLEEDS
_____ PERSISTENT COUGH
_____ RINGING IN EARS
_____ SINUS PROBLEMS
_____ VISION – FLASHES OR HALOS

GASTROINTESTINAL

_____ BLOATING
_____ BLACK OR TARRY STOOLS
_____ BOWEL CHANGES
_____ CHANGE IN APPETITE
_____ CONSTIPATION
_____ DIARRHEA
_____ EXCESSIVE THIRST
_____ GAS
_____ HEMMORHOIDS
_____ INDIGESTION/HEARTBURN
_____ NAUSEA
_____ RECTAL BLEEDING
_____ STOMACH PAIN
_____ VOMITING

HEMATOLOGIC

_____ ANEMIA
_____ EASY BRUISING
_____ EXCESSIVE BLEEDING

RESPIRATORY

_____ CHRONIC COUGH
_____ COUGHING UP BLOOD
_____ WHEEZING OR ASTHMA

URINARY

_____ BLOOD IN URINE
_____ FREQUENT URINATION
_____ LACK OF BLADDER CONTROL
_____ PAINFUL URINATION

NEUROLOGICAL

_____ DOUBLE VISION/VISION LOSS
_____ PRIOR STROKE
_____ MUSCULAR WEAKNES
_____ SPEECH DIFFICULTY
_____ TRANSIENT PARALYSIS
_____ TRANSIENT NEUROLOGIC DEFICIT

MEN ONLY

_____ ERECTION DIFFICULTIES
_____ LUMP IN TESTICLES
_____ PENIS DISCHARGE
_____ SORE ON PENIS
_____ OTHER (PLEASE LIST)

MUSCLE/BONE/JOINT

_____ ARMS
_____ BACK
_____ FEET
_____ HANDS
_____ HIPS
_____ LEGS
_____ NECK
_____ SHOULDERS

Millennium Physicians

TEXAS REGIONAL UROLOGY

NEW PATIENT MEDICAL QUESTIONNAIRE

REVIEW OF SYMPTOMS CONTINUED

CHECK THE SYMPTOMS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR. CHECK ALL THAT APPLY.

_____ AIDS	_____ CHICKEN POX	_____ HIV POSITIVE	_____ POLIO
_____ APPENDICITS	_____ DIABETES	_____ KIDNEY DISEASE	_____ PROSTATE PROBLEM
_____ ARTHRITIS	_____ EMPHYSEMA	_____ LIVER DISEASE	_____ RHEUMATIC FEVER
_____ ASTHMA	_____ EPILEPSY	_____ MEASLES	_____ SCARLET FEVER
_____ BLEEDING DISORDERS	_____ GLAUCOMA	_____ MIGRAINE HEADACHES	_____ STROKE
_____ BREAST LUMP	_____ HEART DISEASE	_____ MULTIPLE SCLEROSIS	_____ THYROID ISSUES
_____ CANCER	_____ HEPATITIS	_____ MUMPS	_____ TUBERCULOSIS
_____ CATARATCS	_____ HERPES	_____ PACEMAKER	_____ ULCERS
_____ CHEMICAL DEPENDENCY	_____ HIGH CHOLESTEROL	_____ PNEUMONIA	_____ VENEREAL DISEASE

WOMEN ONLY

_____ ABNORMAL PAP SMEAR
_____ BLEEDING BETWEEN PERIODS
_____ BREAST LUMP
_____ EXTREME MENSTRUAL PAIN
_____ HOT FLASHES
_____ NIPPLE DISCHARGE
_____ PAINFUL INTERCOURSE
_____ VAGINAL DISCHARGE

DATE OF LAST PERIOD:
AGE AT FIRST PERIOD:
DATE OF LAST PAP SMEAR:
DATE OF LAST MAMMOGRAM:
PRIOR BREAST BIOPSIES: YES or NO
PRIOR BREAST SURGERY? YES or NO
ARE YOU CURRENTLY PREGNANT? YES or NO
NUMBER OF CHILDREN:
AGE WHEN FIRST CHILD WAS BORN:
DID YOU BREAST FEED: YES or NO
IF SO, HOW LONG:
ARE YOU CURRENTLY OR HAVE EVER TAKEN CONTRACEPTIVE: YES or NO
IF SO, HOW LONG:

POST-MENOPAUSAL WOMEN ONLY

AGE AT MENOPAUSE: _____

HAVE YOU EVER TAKEN HORMONE

REPLACEMENT THERAPY? YES or NO

IF YES, FOR HOW LONG? _____

SIGNATURES

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR IF I EVER HAVE A CHANGE IN HEALTH.

SIGNATURE OF PATIENT: _____ **DATE:** _____

Millennium Physicians

TEXAS REGIONAL UROLOGY

ALCOHOL MISUSE/ABUSE (AUDIT C)

PATIENT NAME: _____ **DOB:** _____

DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR? _____ **YES or** _____ **NO**

IF YES, HOW OFTEN DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?

_____ **NEVER (0 POINTS)**

_____ **MONTHLY OR LESS (1 POINT)**

_____ **2 TO 4 TIMES A MONTH (2 POINTS)**

_____ **2 TO 3 TIMES A WEEK (3 POINTS)**

_____ **4 OR MORE TIMES A WEEK (4 POINTS)**

IF YES, HOW MANY DRINKS DID YOU HAVE ON A TYPICAL DAY IN THE PAST YEAR?

_____ **1 TO 2 DRINKS (0 POINTS)**

_____ **3 TO 4 DRINKS (1 POINT)**

_____ **5 TO 6 DRINKS (2 POINTS)**

_____ **7 TO 9 DRINKS (3 POINTS)**

_____ **10 OR MORE DRINKS (4 POINTS)**

IF YES, HOW OFTEN DID UOU HAVE 6 OR MORE DRINKS ON ONE OCCASION IN THE PAST YEAR?

_____ **NEVER (0 POINTS)**

_____ **LESS THAN MONTHLY (1 POINT)**

_____ **MONTHLY (2 POINTS)**

_____ **WEEKLY (3 POINTS)**

_____ **DAILY OR ALMOST DAILY (4 POINTS)**

TOTAL POINTS: _____

INTERPRETATION: _____ **POSITIVE or** _____ **NEGATIVE**

INTERPRETATION: The audit c is scored on a scale of 0-12 (scores 0 reflect no alcohol abuse)
In men, a score of 4 or more is considered positive.
In women, a score of 3 or more is considered positive.

Millennium Physicians

TEXAS REGIONAL UROLOGY

GENERAL CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT

MEDICAL CONSENT: I consent to all medical care, treatment, laboratory, imaging and other medical procedures performed or prescribed by a physician of Millennium Physicians and his/her designees as directed in his/her judgement.

RIGHT TO REFUSE TREATMENT: I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my doctor to further clarify or explain anything I do not understand. This right includes the right to refuse treatments that I do not want.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS & NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received both notices.

ADVANCE DIRECTIVES: I understand that I have an opportunity to make known my wishes, in writing, regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for health care.

RELEASE OF MEDICAL INFORAMTION: I authorize Millennium Physicians to release any information necessary to facilitate health care processing of claims, and audit payments to relative my care/treatment with Millennium Physicians. I also consent to the release of any information as needed for my care to other facilities =, agencies or providers as I direct or as required by law. This order will remain in effect until revoked by myself in writing.

FINANCIAL AGREEMENT: I certify that the insurance information that I have provided is correct and that no other coverage or insurance exists. I understand I am financially responsible to Millennium Physicians for charges not paid under this agreement. I am responsible for all charges for services provided to me which are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. Millennium Physicians will make every attempt to notify me in advance if a service is not covered. I agree to pay all applicable co-payments, deductibles and co-insurance. I am responsible to pay all co-payments, deductibles and co-insurance at the time of service unless other arrangements have been made.

ASSIGNEMNT OF INSURANCE BENEFITS: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medigap, Medicare Replacement, Private Insurance and any other health/medical plan, to issue a payment check(s) directly to Millennium Physicians Association, PLLC for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XV111 of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or related to a Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applied only when applicable.)

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS OF THIS FORM AND THAT I AM AUTHORIZED AS THE PATIENT OR PATIENT'S LEGAL REPRESENTATIVE TO SIGN THIS DOCUMENT.

_____	_____	_____
Patient/Legal Representative Printed Name	**Patient/Legal Representative Signature**	**Date**

Complete this section if form is not signed and dated by the patient or patient's legal representative. I have made a good faith effort to obtain a written acknowledgement of receipt of Millennium Physicians Notice of Privacy Practices but was unable to do so for the following reason:

_____ Patient/Legal Representative refused to signed _____ Patient/Legal Representative unable to sign

Employee Name: _____ Date: _____

Millennium Physicians

TEXAS REGIONAL UROLOGY

PATIENT AUTHORIZATION TO COMMUNICATE AND DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____ **PHONE #:** _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner (CHECK ALL THAT APPLY)

Home telephone:

_____ Leave message with detailed information

_____ Only leave call back information

Cell Phone:

_____ Leave message with detailed information

_____ Only leave call back information

Work Telephone:

_____ Leave message with detailed information

_____ Only leave call back information

Written Correspondence:

_____ Mail to my home address on file

_____ Mail to a different address (list below)

I hereby authorize one or all of the designated parties below to request, discuss and receive any protected health information regarding my health care and treatment. This PHI includes my treatment information, billing, payments or any information in my medical records. I understand that the identity of designees must be verified before the release of PHI.

AUTHORIZED DESIGNEES:

NAME: _____ **RELATIONSHIP:** _____ **PHONE #:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE #:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE #:** _____

This authorization shall remain in effect from the date signed below until revoked. You have the right to revoke this authorization in writing. I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the PHI to be disclosed. I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to disclosure by the above designee.

_____ _____ _____

Patient/Legal Representative Printed Name **Patient/Legal Representative Signature** **Date**

_____ I REVOKE/CANCEL THIS AUTHORIZATION

_____ _____ _____

Patient/Legal Representative Printed Name **Patient/Legal Representative Signature** **Date**

TEXAS REGIONAL UROLOGY

HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

This record will authorize Texas Regional Urology, PLLC to release OR to obtain from any listed provider or facility a copy, summary or narrative of my medical records as indicated by the check mark(s) below, or to otherwise release confidential information. At this time, I am requesting the following:

_____ Complete record

_____ Records of care from _____ to _____ only.

_____ Records of care concerning the following condition(s): _____

_____ Other (specify): _____

Name of Physician/Medical Facility: _____

Address: _____

Phone: _____ Fax: _____

Reason for request: review and continue care

I understand that the information in my health record may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral mental health services and treatment for alcohol or drug abuse.

_____ **Yes, I consent to the release of this information.** _____ **No, I do not consent to the release of this information.**

I understand that the information released is for the purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to insure treatment.

I understand that you will provide this information within 15 business days from the receipt of request, and you may charge a fee for preparing and furnishing this information. The fee is waived because the records are to be used for supporting an application for disability or other benefits, or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income and Federal Old-Age and Survivor's Insurance. I have attached a statement which confirms that such application or appeal has been filed or is pending.

Signature: _____ **Date:** _____

(Patient or person legally authorized to consent on patient's behalf)

9303 Pinecroft Dr. #320

The Woodlands, TX 77380

P# 832-442-2392 F# 832-442-2398

Millennium Physicians

TEXAS REGIONAL UROLOGY

PATIENT CANCELLATION POLICY

OFFICE VISIT CANCELLATION: We require a 24 hour notice of cancellation for office visit appointments. If not notified timely, there will be a $25.00 no show fee assessed to your account.

OFFICE PROCEDURE CANCELLATION: We require a 24 hour notice of cancellation for office visit procedures. If not notified timely there will be a $50.00 no show fee assessed to your account or retention of the deposit collected in advance; i.e. $100 vasectomy deposit, $75 urodymanics deposit.

SURGERY CANCELLATION: Surgery scheduling involves a significant amount of work with coordination o multiple disciplines including physician, nursing, administration insurance, medical suppliers and the facility. Because cancellation can result in unused operative resources, we require a minimum of 72 hours (3 business days) notification should you need to cancel or reschedule your surgery. This allows the physician/facility time to schedule another patient. Failure to notify us of cancellation in the required time will result in a $250.00 no show fee assessed to your account. **IF YOU MUST CANCEL YOUR SURGERY PLEASE CALL 281-290-9800**

All cancelation fees must be paid prior to rescheduling your appointment or surgery. Exceptions to this policy will be made at the discretion of your physician for emergencies and conflicts beyond your control.

I have read this policy and understand the cancelation fees as outlined.

_____ _____

Patient printed name **DOB**

_____ _____

Patient/Legal Representative Signature **Date**

Millennium Physicians

TEXAS REGIONAL UROLOGY

PRIOR AUTHORIZATION FOR ANY PRESCRIBED MEDICATIONS

Please note, if we write any medications that are rejected by your insurance company we will no longer submit a "Prior Authorization". It will be your responsibility to contact your insurance company to determine what medications are on their formulary list.

I fully understand that I am aware that I should contact my insurance company and to call back with a list of medications that are approved by my insurance company.

_____ _____

Patient printed name **DOB**

_____ _____

Patient/Legal Representative Signature **Date**