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Welcome to our practice! Thank you for choosing South County Urological, Inc. Our commitment to excellence demands that we treat each patient and family member with mutual respect, dignity, and compassion. We are committed to doing so and providing you with outstanding medical care.

In addition to seeing a physician in our office, you may be seen by other health care providers, if needed, for the treatment of your condition. These providers would include physician assistants, nurses, etc.

Enclosed you will find an appointment card confirming your appointment time with your doctor. Please review your appointment information. If your records reflect a different date or time, please call our office at 314-843-8000.

Also enclosed is a patient information packet. **Please complete this paperwork and mail it back in the self-addressed stamped envelope enclosed.** If you have a health insurance plan that requires a referral to see a specialist, please bring your referral with you. We will take a copy of your insurance card when you get here, so please bring your current health insurance identification card with you, as well as another form of ID.

South County Urological, Inc. is located at the corner of Tesson Ferry and West Bend Drive in a building titled "Medical Building," directly across from a gas station. Our address is 12345 West Bend Drive, Suite 200. If you need further directions, please do not hesitate to call.

Again, thank you for choosing South County Urological for all your urological needs. We look forward to meeting you.

Sincerely,

South County Urological

South County Urological, Inc.

Today's Date: _____ SS#: _____
Patient Name: _____ Date of Birth: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Mailing Address if different than above: _____
Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____
Email Address: _____
Preferred Method of Contact (circle one) Home Cell Work Email
Can we leave a message on this phone number? (circle one) Yes No

Email/text communication may be available, however, as with all unencrypted emails/texts there may be some level of risk, meaning regular email/texts can be read/intercepted by someone else.
Can we contact you via Email? (circle one) Yes No Text? (circle one) Yes No

Primary Doctor: _____ Who referred you to our office: _____
Employer: _____ Phone: ( )_____
Employer's Address: _____
Spouse's Name: _____ SS#: _____
Spouse's Employer: _____ Phone: ( )_____
Spouse's Birth Date: _____

Please circle the appropriate choice:

RACE
African American
Asian
Pacific Islander
American Indian
White
Other_____

ETHNICITY
Hispanic or Latino
Not Hispanic or Latino

PREFERRED LANGUAGE
Arabic Serbo-Croatian
English Spanish
German Greek
Other: _____

Insurance Information

Primary Insurance: _____
Subscriber's Name: _____ Subscriber's Birth Date: _____
ID# _____Group: _____
Secondary Insurance: _____
Subscriber's Name: _____ Subscriber's Birth Date: _____
ID# _____Group: _____

Emergency Contact: _____ Phone: ( ) _____
Relationship to the above contact: _____

South County Urological, Inc

AUTHORIZATION TO COMMUNICATE INFORMATION TO OTHERS

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Please list the name and relationship to you of family members and friends with whom we may discuss your protected health information:

Name: _____ Relationship to Patient: _____ Contact #: _____
May Discuss Diagnosis/Treatment Yes___ No ___ May Discuss Billing Info Yes ___ No ___

Name: _____ Relationship to Patient: _____ Contact #: _____
May Discuss Diagnosis/Treatment Yes___ No ___ May Discuss Billing Info Yes ___ No ___

Name: _____ Relationship to Patient: _____ Contact #: _____
May Discuss Diagnosis/Treatment Yes___ No ___ May Discuss Billing Info Yes ___ No ___

Purposes of Use or Disclosure: Treatment, administrative operations of South County Urological, Inc. or answering inquires by the parties listed above.

I understand that these authorizations are voluntary and that I can refuse to sign the authorization. I understand I may revoke this authorization at any time. I understand I do not have to sign this form to receive care. I understand it is my responsibility to update this list in order to keep accurate who can obtain information about my health. I understand that this authorization will expire when a period of two (2) years has run without me receiving treatment from this practice.

_____ _____
Patient/Legal Representative Date

Patient unable to sign form due to _____

SIGN BELOW ONLY IF YOU WISH TO REVOKE YOUR AUTHORIZATION

I hereby revoke this authorization_____ Date _____

South County Urological, Inc

FINANCIAL AGREEMENT

Thank you for choosing South County Urological, Inc as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which will require you to read and sign prior to any treatment.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE PHYSICIAN. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND A PHOTO I.D. FOR YOUR FILE. ANYTIME YOU CHANGE INSURANCE PLEASE UPDATE US WITH YOUR NEW INSURANCE INFORMATION SO WE CAN PROPERLY FILE YOUR CLAIM.

APPOINTMENTS – 24 hours' notice must be provided in the event you cannot keep an appointment, a cancellation fee of $25.00 may then be added to your account. Cancellations for Procedures or Ancillary Services will have a higher fee.
REFERRALS/AUTHORIZATION– If your plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment. If you do not have a referral, you may be asked to reschedule your appointment until you obtain a proper referral. It is your responsibility to inform the office staff if your insurance requires you to utilize a specific hospital/lab/facility for medical services rendered or order by this office.
CO-PAYMENTS – By law we MUST collect the copay designated by your insurance carrier. This is part of your contract with the insurance company and noncompliance may result in your insurance company cancelling your policy.
SURGERY DEPOSITS – If you and your physician determine that your course of care requires surgery, a surgical deposit may be collected at the time of scheduling. Our Billing/Scheduling Coordinators will work with you to determine estimated insurance payment and estimated patient responsibility. Any procedure performed in this office could be deemed surgical by your insurance company and all copays and deductibles will apply.
MEDICARE/INSURANCE – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one. We are a Medicare participating Group and therefore accept assignment from Medicare. We do not accept assignment from other insurance companies unless we are contracted with them. We will, however, be happy to assist you in filing claims for reimbursement from other insurance companies. Please remember that insurance is considered a method of reimbursing you, the patient, for fees paid to the doctor and is not a substitute for payment. The patient is responsible for payment of health care regardless of the status of his/her claim. Reduction or rejection of your claim by your insurance company does not relieve you of the financial obligation incurred for medical services rendered. It is your responsibility to obtain benefit information and to pay all deductibles, coinsurances, or other balance not covered by your insurance. The patient or guardian (if patient is a minor) is responsible for the account regardless of insurance coverage.
SELF-PAY PATIENTS – Payment is expected at the time of service.
INSUFFICIENT FUND CHECKS – A $35.00 fee will be charged to patient's account for checks returned due to non-sufficient funds.
**Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize medical benefits to South County Urological, Inc, for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize South County Urological, Inc. to release medical information about me to my insurance company concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administrating claims and benefits.
**Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits to be made on my behalf to South County Urological, Inc for any services furnished to me. I authorize South County Urological, Inc to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluation and administering claims of benefits.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AND DISCOVER. Thank you for taking the time to review our policies.
Patient name: _____ Date of Birth: _____
Responsible Party Signature: _____ Today's Date: _____

South County Urological, Inc

We would like you to help us learn more about our patients.
Please complete this form and return to the receptionist.

Patient Name_____ Date_____

How did you hear about us?

My friend/relative _____ recommended the doctor.

My physician _____ recommended the doctor.

I heard/saw about you on:

PBS – channel 9_____

KSKD – channel 5_____

Other TV station _____

South County Urological Website

Facebook _____

Other social media _____

The Point 105.7_____

KMOX _____

Radio Station _____

Referred from hospital/emergency department_____

I attended the lecture/webinar on _____ at _____.
(topic) (event)

Other (please specify) _____.

MEDICAL HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____

By what method did you choose our practice? Referring Physician _____Friend _____
Yellow Pages __ Insurance Company __ Radio or TV ad __ Internet __ Other (please explain) _____

Why are you seeing the doctor today? _____

Have any tests been performed for this problem? Yes or No What was done? _____

Where and when were the test(s) performed? _____

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: (dull, sharp, etc.) _____

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

PAST MEDICAL HISTORY. Please CIRCLE if you have or have had any of the following diseases or conditions:

ADD	Chronic Fatigue Syndrome	Gastric Cancer	Malaise
ADHD	Chronic Liver Disease	GERD	Melanoma
Alcoholism	Chronic Renal Insufficiency	Glaucoma	Mental Illness
Allergies	Chronic Renal Failure	Goiter	Migraine
Alzheimer's	Colitis	Gout	Mitral Stenosis
Anemia	Constipation	Hay Fever	Mitral Insufficiency
Aneurysm	Colon Cancer	Heart Attack	Mitral Valve Prolapse
Angina	Colon Condition	Heart Disease	Mumps
Anorexia	Congenital Heart Disease	Heart Valve Problem	Nervous Breakdown
Anxiety Disorder	Congenital Heart Failure	Heart Murmur	Obesity
Arthritis	Crohn's Disease	Hemorrhoids	Osteoporosis
Arrhythmia	Deafness	Hepatitis	Pancreatitis
Aortic Stenosis	Deep Vein Thrombosis	Herniated Disc	Peptic Ulcer
Aortic Insufficiency	Depression	Hiatal Hernia	Phlebitis
Asthma	Diabetes Insulin-Dependent	High Cholesterol	Polio
Atrial Fibrillation	Diabetes Non-Insulin-Dependent	High Blood Pressure	Prostate Cancer
Back Pain	Diabetes Uncontrolled	Impaired Glucose Tolerance	Prostatitis
BPH	Diarrhea	Infectious Disease	Pulmonary Embolism
Bi-polar Disorder	Eating Disorder	Infertility	Rectal Fissure
Bladder Cancer	Ear Infections	Irritable Bowel Disease	Rectal Cancer
Bleeding Disorder	Elevated PSA	Inflammatory Bowel Disease	Rheumatic Fever
Blindness	Emphysema	Kidney Disease	Sexually Trans. Disease
Brain Tumors	Enlarged Heart	Laryngeal Cancer	Sickle Cell Anemia
Breast Cancer	Epilepsy	Leukemia	Stroke
Bronchitis	Fibrocystic Breast Disease	Liver Disease	Suicide Attempt
Cataracts	Fibromyalgia	Lung Cancer	Testicular Cancer
Cerebrovascular Disease		Lung Disease	Thyroid Disease
Cholecystitis		Lymphoma	Tuberculosis
Cholelithiasis			

Other:_____

SURGICAL HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____

PAST SURGICAL HISTORY

Please CIRCLE if you have or have had any surgeries and write date of surgery:

Amputation
Angioplasty
Aortic Aneurysm Repair
Arthroscopic Surgery
Back Surgery
Bariatric Surgery
Bladder Surgery
Bowel Resection
Brachytherapy
Brain Surgery
Breast Surgery
Biopsy of Prostate
CABG
Carotid Artery Surgery
Carpal Tunnel Surgery (R or L or Both)
Cataract Surgery (R or L or Both)
Cervical Spine Surgery
Cholecystectomy
Circumcision
Colon Resection
Colonoscopy
Corneal Surgery (R or L or Both)
Cystoscopy
Cysto- TUR Fulguration
Cyst Removal
Deliveries (Vaginal or C-Section)
Ear Surgery (R or L or Both)
EGD
Epididymectomy
ESWL
Eye Surgery (R or L or Both)
Facial Surgery
Foot Surgery (R or L or Both)
Gastric Surgery
Hand Surgery (R or L or Both)
Hysterectomy
Heart Surgery
Heart Transplant
Hemorrhoidectomy
Hip Surgery (R or L or Both)
Hydrocelectomy
Ileal Conduit
Ileostomy
Indigo Laser Surgery
Inguinal Hymenorrhaphy
Knee Surgery (R or L or Both)
Laminectomy
Laparoscopy
Laparotomy
Leg Surgery (R or L or Both)
Liver Surgery
Lumpectomy
Lung Surgery
Lymphatic Node Dissection
Lysis Adhesions
Mastectomy
Mastoid Surgery
Meatotomy
Nasal Surgery
Ventral Hernial
Needle Biopsy
Nephrectomy
Nephrolithotomy
Orchiectomy
Pacemaker Insertion
Parathyroidectomy
Penile Implant
PEG
PE Tubes
Pilonidal Cyst Incision
Radical Prostatectomy
Renal Transplant
Rotator Cuff Surgery
Septoplasty
Sinus Surgery
Skin Grafting
Spermatocelectomy
Stomach Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery
TUMT Prostate
TUR Prostate
Umbilical Hernia Repair
Ureteroscopy
Varicocelectomy
Vasectomy
Vein Stripping
VLAPP

Other: _____

_____

FAMILY HISTORY

Please list which family member has/had any of the following: (Mother, Father, Siblings, Grandparents)

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

SOCIAL HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____

Please provide the following information:

Marital Status:_____ (Please indicate years) Single __ Married __ Separated __ Divorced __ Widowed __
Life Partner __ Common Law Spouse __

Dependents: Please indicate # of each, if you have:
_____Sons __ Daughters __ Stepchildren __ Adopted __ Foster __ Parents __ Grandparents __

Occupation: Please circle one that applies:
None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other _____

Hobbies: Please circle any that apply to you:
None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

Alcohol Consumption: Do you drink alcohol? _____ Yes __ No __
If yes: Occasionally/Socially __ #of drinks per week __ How long _____

Tobacco: Do you smoke? Yes __ No __ If yes: #___ Packs /day #___ Cigarettes/day ___ Smokeless Tobacco
Have you ever smoked? Yes __ No __ If yes: #___ Packs /day #___ Cigarettes/day ___ Smokeless Tobacco
If you previously smoked, when?_____ How long? _____

Recreational Drugs: ___ None If yes, please list:_____

Caffeinated beverages: ___ None _____Low _____Moderate _____Excessive

ALLERGIES- Please list ALL types (Drugs, Seasonal, Pets, Environmental, Foods)

_____

_____

Recent Foreign Travel: ___ None _____Americas _____Worldwide

CURRENT MEDICATIONS: Please list ALL medications you are currently taking, including over the counter medications.
Drug Name: Strength: Directions/How you take it:

Attach list if necessary

Do you grant us permission to import your medications from your pharmacy: _____ Yes _____No

Pharmacy Name: _____

Location: _____

Review of Systems

Name: _____ Date of Birth: _____ Today's Date: _____

Please CIRCLE if you have or have had any of the following:

Constitutional:

Aches/Pains	Anorexia	Appetite Changes	Bruises Easily
Chills	Fatigue	Fever	Generalized Weakness
Hot Flashes	Insomnia	Loss of Energy	Night Sweats
Swollen Glands	Weight Gain	Weight Loss	

Eyes:

Blind	Blurry Vision	Double Vision	Eye Pain

Ears, Nose, Mouth, Throat:

Dry Mouth	Hearing Loss	Sinus Problems	Sore Throat

Cardiovascular:

Chest Pain/Angina	Hardening of Arteries	Heart Murmur	High Blood Pressure
Irregular Heartbeat	Pain/Cramps with exercise	Palpitations	Swelling
Skipped Heartbeat			

Respiratory:

Cough	Shortness of Breath	Wheezing

Gastrointestinal:

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

Genitourinary:

Bedwetting	Blood in Urine	Burning on Urination	Dribbling
Erection Problems	Flank Pain	Kidney Infection	Kidney Failure
Low Desire	Nocturia	Premature Ejaculations	Prostate Infection
Sexual Dysfunction	STDs	Suprapubic Pain	Testes/Scrotal Pain
Urgency	Urinary Frequency	Urinary Incontinence	Urinary Hesitancy
Urine Retention	Urinary Tract Infections	Weak Stream	

Musculoskeletal:

Arthritis	Back Pain	Joint Pain	Muscle Cramps
Muscle Weakness	Neck Pain/Stiffness	Sore Muscles	

Integumentary/Skin:

Rash	Dry Skin	Bruising	Lesions/Ulcers

Neurological:

Balance Problems	Disoriented	Dizzy Spells	Headache
Memory Loss	Lack of Alertness	Lack of Awareness	Leg or Arm Pain
Numbness/Tingling	Tremors		

Hematologic/Lymphatic:

Bleeds Easily	Blood Clots	Hepatitis C	HIV (AIDS)
Swollen Glands			

Allergy/Immunologic:

Animal	Drug	Environmental	Seasonal

Endocrine:

Diabetes	Excess Thirst	Heat/Cold Intolerance	Pituitary Disease
Tired/Sluggish	Thyroid Disease		

Psychological:

Anxious	Considered suicide	Depressed	Not satisfied with life