

SOUTHEASTERN  
**UROLOGY**  
ASSOCIATES  
*specializing in minimally invasive & robotic surgery*

W. Winston Wilfong, MD

Lancing C. Patterson, MD

Victor J. Address, MD

380 HOSPITAL DRIVE, BUILDING A, SUITE 320 • MACON, GA 31217

478-742-5331 phone • 478-750-1387 fax • [www.seurology.com](http://www.seurology.com)

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*Thank you for choosing Southeastern Urology Associates for your medical needs.*

Please arrive 15 minutes prior to your appointment time.

Late arrivals will be rescheduled or seen last.

Please complete the enclosed forms and bring the completed forms  
to our office at your appointment.

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

Account Number: \_\_\_\_\_

You were referred by \_\_\_\_\_ for \_\_\_\_\_.

**Your appointment is with:**

\_\_\_\_\_ Dr. Wilfong    \_\_\_\_\_ Dr. Patterson    \_\_\_\_\_ Dr. Address

**Your appointment is scheduled for:**

\_\_\_\_\_ at \_\_\_\_\_ am  
\_\_\_\_\_ pm

\_\_\_\_\_ Macon Office    \_\_\_\_\_ Warner Robins Office

**\*\*Please Note\*\***

We will ask for proof of health insurance and picture identification at every visit due to insurance requirements.

**A referral is required for all HMO's and POS's.**

It is your responsibility as the patient to obtain the referral number and provide our office with this information prior to your visit. Co-payments and/or Co-Insurances are due at the time service is rendered.

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

**!! IMPORTANT !!**

**Please list all medications you are currently taking and their strength:  
(Prescription and Over-the-counter medications)**

	DRUG NAME	/	DRUG STRENGTH
1.	_____		
2.	_____		
3.	_____		
4.	_____		
5.	_____		
6.	_____		
7.	_____		
8.	_____		
9.	_____		
10.	_____		
11.	_____		
12.	_____		
13.	_____		
14.	_____		

List all drug allergies: \_\_\_\_\_  
\_\_\_\_\_

Name of Pharmacy/Drug Store You Use: \_\_\_\_\_

Location: \_\_\_\_\_ (City)  
(Street Name)

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DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**REASON YOU ARE SEEING THE DOCTOR TODAY?** \_\_\_\_\_

**SOCIAL HISTORY:**

Marital Status (Please circle one):    Single    Married    Widowed    Divorced  
How many children do you have? \_\_\_\_\_    How many still live at home? \_\_\_\_\_

**HABITS:**

**Do you smoke?** \_\_\_\_\_    If yes, how many packs per day? \_\_\_\_\_  
If no, have you been a smoker in the past? \_\_\_\_\_  
If so, what year did you quit? \_\_\_\_\_

**Do you drink alcohol?** \_\_\_\_\_  
If so, how many alcoholic beverages do you average per day? \_\_\_\_\_

**Do you drink caffeinated beverages?** \_\_\_\_\_  
If so, how many cups of coffee \_\_\_\_\_, Iced Tea \_\_\_\_\_ and Cokes \_\_\_\_\_ per day?

**EMPLOYMENT:**

Are you employed? \_\_\_\_\_    Employer: \_\_\_\_\_  
If employed, what type of work do you do? \_\_\_\_\_  
If retired, where were you employed and what type of work did you do? \_\_\_\_\_

**MEDICAL ILLNESSES:** Medical illnesses that you have been diagnosed with or treated. (Examples: High blood pressure, diabetes, heart disease, emphysema, cancer, bleeding disorders, etc.)

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

**PRIOR SURGERIES:** List any operations you have had and the year you had them.

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

**FAMILY HISTORY:** List any illnesses in your immediate family. (Examples: Kidney or Bladder Problems, Prostate Problems, Bleeding Disorders, Breast Cancer, Prostate Cancer, etc.)

Mother \_\_\_\_\_                      Father \_\_\_\_\_  
Grandmother \_\_\_\_\_              Grandfather \_\_\_\_\_  
Sister \_\_\_\_\_                      Brother \_\_\_\_\_

**LONG REVIEW OF SYSTEMS**

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

Date of Birth: \_\_\_\_\_

**Do you currently have any of the following problems? Please check yes or no.**

**CONSTITUTIONAL SYMPTOMS**

Weight Loss                    \_\_\_ Yes \_\_\_ No  
 Appetite Increase           \_\_\_ Yes \_\_\_ No  
 Appetite Decrease         \_\_\_ Yes \_\_\_ No  
 Chills                           \_\_\_ Yes \_\_\_ No  
 Fever                           \_\_\_ Yes \_\_\_ No

**NEUROLOGICAL**

Dizzy Spells                 \_\_\_ Yes \_\_\_ No  
 Numbness                    \_\_\_ Yes \_\_\_ No  
 Stroke                        \_\_\_ Yes \_\_\_ No  
 Tremors                      \_\_\_ Yes \_\_\_ No

**ENDOCRINE**

Diabetes                      \_\_\_ Yes \_\_\_ No  
 Thyroid Disease            \_\_\_ Yes \_\_\_ No  
 Pituitary Disease         \_\_\_ Yes \_\_\_ No

**GASTROINTESTINAL**

Abdominal Pain            \_\_\_ Yes \_\_\_ No  
 Black Stools                \_\_\_ Yes \_\_\_ No  
 Heartburn/Indigestion   \_\_\_ Yes \_\_\_ No  
 Constipation               \_\_\_ Yes \_\_\_ No  
 Diarrhea                    \_\_\_ Yes \_\_\_ No  
 Bloody Stools              \_\_\_ Yes \_\_\_ No  
 Rectal Bleeding            \_\_\_ Yes \_\_\_ No  
 Nausea/Vomiting         \_\_\_ Yes \_\_\_ No

**CARDIOVASCULAR**

Angina (Chest pain)      \_\_\_ Yes \_\_\_ No  
 Irregular Heartbeat      \_\_\_ Yes \_\_\_ No  
 Mitral Valve Prolapse    \_\_\_ Yes \_\_\_ No  
 Swelling                    \_\_\_ Yes \_\_\_ No

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

**SKIN**

Persistent Itching        \_\_\_ Yes \_\_\_ No  
 Skin Rash                  \_\_\_ Yes \_\_\_ No

**VACCINES**

Have you had a flu vaccine? \_\_\_ Yes \_\_\_ No  
 Have you had a pneumonia vaccine? \_\_\_ Yes \_\_\_ No

**MUSCULOSKELETAL**

Arthritis                    \_\_\_ Yes \_\_\_ No  
 Joint Pain                 \_\_\_ Yes \_\_\_ No

**RESPIRATORY**

Asthma                      \_\_\_ Yes \_\_\_ No  
 Chronic Cough            \_\_\_ Yes \_\_\_ No  
 Bronchitis                \_\_\_ Yes \_\_\_ No  
 Short of Breath          \_\_\_ Yes \_\_\_ No  
 Emphysema                \_\_\_ Yes \_\_\_ No  
 Tuberculosis              \_\_\_ Yes \_\_\_ No  
 Environmental  
     Allergies                \_\_\_ Yes \_\_\_ No

**HEMATOLOGICAL**

Bleeding Problem        \_\_\_ Yes \_\_\_ No  
 Hepatitis                  \_\_\_ Yes \_\_\_ No  
 HIV (Aids)                \_\_\_ Yes \_\_\_ No  
 IV Drug use                \_\_\_ Yes \_\_\_ No  
 Swollen  
 Lymph Nodes              \_\_\_ Yes \_\_\_ No  
 Sickle Cell                 \_\_\_ Yes \_\_\_ No

**FOR WOMEN:**

Involuntary Urine Leakage \_\_\_ Yes \_\_\_ No

**FOR MEN: LAST PSA:**

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

Value: \_\_\_\_\_

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**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Social Security: \_\_\_\_\_ Patient Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: (Circle one) Male Female

Home Address: \_\_\_\_\_

(Street)

City \_\_\_\_\_ State \_\_\_\_\_ Zip code: \_\_\_\_\_

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

Email Address: \_\_\_\_\_

**PREFERENCE FOR APPOINTMENT REMINDERS:**

\_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email

Preferred Language: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Marital Status: (Circle one) Single Married Widowed Divorced

Spouse Name: \_\_\_\_\_ Spouse Home/Work/Cell Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Co. Name: \_\_\_\_\_

Primary Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Employer: \_\_\_\_\_

Secondary Insurance Co Name: \_\_\_\_\_

Primary Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Employer: \_\_\_\_\_



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## Assignment of Benefits/Disclosure of Investment Interest

### READ AND SIGN BELOW

#### Financial Information

I acknowledge full financial responsibility for services rendered by Southeastern Urology Associates. I understand payment is due at time of service unless other definite arrangements have been made prior to treatment.

I understand I am responsible for any un-met deductibles and co-insurance fees.

I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform the staff of Southeastern Urology Associates, as to which my insurance covers.

I further authorize and request that insurance payments be made directly to Southeastern Urology Associates for services rendered.

I will allow verification for my appointments through your automated system and if I am not available at my given resources, the message can be left on my automated message system.

#### Consent for Treatment

I have read and fully understand the above consent for treatment, release of information, financial responsibility, and insurance authorization.

#### DISCLOSURE OF INVESTMENT INTEREST

You, the patient, have a right to obtain health care services of supplies from any facility of your choice, unless otherwise restricted by law, including but not limited to, those listed below in which your provider has an interest.

Southeastern Urology Associates, providing Computerized Tomography, also known as CT Scan

Coliseum Same Day Surgery Center, providing Ambulatory Surgery Services (ASC)

Georgia Litho Group, LLLP

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Authorization for Release of Information - Compound Release

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ is authorized to release protected health information about the above named patient in the following manner and to persons listed.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays Other _____
<input type="checkbox"/> Spouse (provide name and phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Medical
<input type="checkbox"/> Other (provide name, phone number and relationship) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication - provide email address* _____ <input type="checkbox"/> Text - please provide cell number* _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Breach notification

For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed or described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign the authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

\_\_\_\_\_  
 Signature of Patient or Personal Representative      Date \_\_\_\_\_

\*Description of Personal Representative's Authority (attach necessary documentation)

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## Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have received a copy of the Notice of Privacy Practices for the above named practice.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

### For Office Use Only

**We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:**

- **An emergency existed and a signature was not possible at the time.**
- **The individual refused to sign.**
- **A copy was mailed with a request for a signature by return mail.**
- **Unable to communicate with the patient for the following reason:**

\_\_\_\_\_

- **Other:** \_\_\_\_\_

\_\_\_\_\_

Prepared By \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_