SOUTHEASTERN
UROLOGY
ASSOCIATES
specializing in minimally invasive & robotic surgery

W. Winston Wilfong, MD Lancing C. Patterson, MD
Victor J. Andress, MD

380 HOSPITAL DRIVE, BUILDING A, SUITE 320 • MACON, GA 31217
478-742-5331 phone • 478-750-1387 fax • www.seurology.com
233 NORTH HOUSTON ROAD, SUITE 140F • WARNER ROBINS, GA 31093
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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. Andress

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: _____ _____
(Street Name) (City)

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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 _____

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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:_____

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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.
☐ Voice Mail	☐ Results of lab tests/x-rays Other _____
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Appointment Reminders ☐ Medical
☐ Other (provide name, phone number and relationship) _____ _____ _____	☐ Financial ☐ Appointment Reminders ☐ Medical
☐ Email communication - provide email address* _____ ☐ Text - please provide cell number* _____ * In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment Reminders ☐ 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.

_____ Date _____

Signature of Patient or Personal Representative

***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 _____