Milwaukee Urology
SPECIALISTS
CHARLES F. KIDD, MD
ELLIOTT C. SILBAR, MD
RACHEL M. QUINN, MD

PATIENT HEALTH HISTORY

Today's date ___________ **Date of Last Physical Exam**_____________ **Referring Physician**____________________

Last Name _________________________ **First Name**______________________ **Middle Name**________________

Date of Birth__________________**Social Security #:** ____________________ **Weight** _______ **Height**_______

What is the main reason for your visit today?____

Please list any allergies you have____

____ ☐ **NONE**

Please list your current Medications ____

____

____ ☐ **NONE**

Surgical History please indicate any surgeries that you had, including approximate date

☐ Appendix____________________ ☐ Hip Replacement _______________ ☐ Tonsils____________________

☐ Bladder Surgery______________ ☐ Hysterectomy __________________ ☐ Vasectomy _______________

☐ Gallbladder _________________ ☐ Knee Replacement_______________ ☐ Hernia Repair_____________

☐ Prostate Surgery _____________ ☐ Other __________________________ ☐ Other_____________________

Family History - Do you have blood relatives with any of the following conditions?

☐ Kidney Stones if yes, who?____________________________

☐ Kidney Disease if yes, who?____________________________

☐ Kidney Cancer if yes, who?____________________________

☐ Bladder Infections if yes, who?____________________________

☐ Bladder Cancer if yes, who?____________________________

☐ Prostate Cancer if yes, who?____________________________

☐ Breast Cancer if yes, who?____________________________

☐ Diabetes if yes, who?____________________________

☐ Heart Disease if yes, who?____________________________

Social History: Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner

Are you a smoker? ☐ YES ☐ NO If so, how much?______________

Are you a former smoker? ☐ YES ☐ NO If so, date quit? ______________

Do you use alcohol? ☐ YES ☐ NO If so, how much? _____________

Do you drink caffeinated beverages? ☐ YES ☐ NO If so, how many? _____________

Do you use recreational drugs? ☐ YES ☐ NO If so, what? __________________

Have you had a blood transfusion? ☐ YES ☐ NO If so, dates: __________________

Race: ☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian

☐ American Indian or Alaskan Native ☐Native Hawaiian or Pacific Islander ☐ Unknown

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Declined

Occupation:_______________________________ Retired? ☐ YES ☐NO

Review of Systems

Fever	Y	N	Incontinence	Y	N
Chills	Y	N	Painful Urination	Y	N
Weight Loss	Y	N	Blood in Urine	Y	N
Blurry Vision	Y	N	Chronic Back Pain	Y	N
Cataracts	Y	N	Chronic Neck Pain	Y	N
Double Vision	Y	N	Muscle Pain	Y	N
Hearing Loss	Y	N	Rash	Y	N
Nasal Stuffiness	Y	N	Persistent Itching	Y	N
Sore Throat	Y	N	History of Skin Cancer	Y	N
Chest Pain	Y	N	Numbness	Y	N
Swollen Ankles	Y	N	Tingling	Y	N
Irregular Heartbeat	Y	N	Dizziness	Y	N
Shortness of Breath	Y	N	Swollen Glands	Y	N
Wheezing	Y	N	Abnormal Bleeding	Y	N
Chronic Cough	Y	N	History of Blood Transfusion	Y	N
Abdominal Pain	Y	N			
Nausea/Vomiting	Y	N			
Constipation/Diarrhea	Y	N			

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Patient Registration Form
(Please Print)

Patient Name: ____________________ _______________ ____ Social Security Number: ________ - ________ - ________
Last First Initial

Date of Birth: _____/_____/_____ Sex: M____ F _____ (Circle one) Single Married Widowed Divorced

Address:____
(Street) (City/State/Zip)
Home Phone: (______) _____________Cell Phone: (______) ___________ Work Phone: (______) __________________

How do you want us to confirm your future appointments: Choose One
Automated Phone Call: ( ) ________ - _____________ Text Message to: (______) _______ - ________________
Email: ____

Employer Name: ________________________________ Employer Phone Number: (______) _________________________

Employer Address: ____
(Street) (City/State/Zip)

Primary Care Physician: ______________________Office Phone:________________Fax:_________________________
Pharmacy Name: ________________________________Phone: _______________ Fax:_________________________
Pharmacy Address: ____

How did you hear about our Practice? ____
Who to call in case of an emergency:
Name: ________________________________ Address____
Home Phone: (_____) ___________ - ______________ Work Phone: (______) __________-_______________________
Relationship: ____

PRIMARY INSURANCE INFORMATION
Plan Name: ____ I.D. Number: ________________________________
Address: ____ Group Number: ______________________________
Policy Holder: ______________________________________ Effective Date: ______________________________
Policy Holder's SS Number: _________ - ________ - ________ Policy Holder's Date of Birth: _____/_____/_____

SECONDARY INSURANCE INFORMATION
Plan Name: ____ I.D. Number: ________________________________
Address: ____ Group Number: ______________________________
Policy Holder: ______________________________________ Effective Date: ______________________________
Policy Holder's SS Number: _________ - ________ - ________ Policy Holder's Date of Birth: _____/_____/_____

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PATIENT CONSENT FOR USE AND
DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION
45 CFR & 164.506

Name: ____

Date of Birth: ____________________

By signing this form you are consenting to **Milwaukee Urology Specialists, S.C.** use and disclosure of your protected health information to carry out treatment, payment or health care operations. For a more complete description of such uses and disclosures, please refer to our Notice of Privacy Practices.

If you do not agree to sign this form, **Milwaukee Urology Specialists, S.C.** may refuse to treat you.

You have the right to review our Notice of Privacy Practices prior to signing this consent. However, we reserve the right to change our privacy practices and change the terms of the Notice. Any new notice of provisions will be effective for all protected health information that we maintain.

You have the right to request that **Milwaukee Urology Specialists, S.C.** restrict how we use and disclose your protected health information. We are not required to agree to such restrictions, but if we do, the restriction will be binding on us. If we do agree, we will restrict our use and disclosure to the extent we document such in writing and notify you of the same.

You have the right to revoke this consent in writing at any time except to the extent that Milwaukee Urology Specialists, S.C. has acted in reliance on it.

I understand and agree to the foregoing:

____ Date: _______________
Signature of Patient/or
Personal Representative of Patient

____ Date: ________________
If Personal Representative, Indicate Relationship to Patient

You may request a copy of this signed consent form upon request

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PERSONAL MEDICAL INFORMATION DISCLOSURE

Patient Name ______________________________________Date of Birth __________

I give permission to **Milwaukee Urology Specialists, S.C.** physicians and staff to speak to the following person(s) regarding my condition and care.
This letter shall stay in my medical record permanently, or until such time I revoke this permission either in writing or over the phone:

Name	Relationship to Patient
______________________________	____________________
______________________________	____________________
______________________________	____________________

PATIENT/GUARDIAN
SIGNATURE______________________________________DATE________________

RELEASE OF INFORMATION

I hereby authorize **Milwaukee Urology Specialists, S.C.** to release any medical or incidental information that may be necessary for either my medical care, or processing of insurance claims.

ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to **Milwaukee Urology Specialists, S.C.** for all charges whether or not they are covered by my insurance plan(s). I also recognize that I am fully responsible for any charges incurred if I do not supply **Milwaukee Urology Specialists, S.C.** with my proper insurance information and /or referral required by my insurance carrier.

I certify that the information given by me in applying for payment is correct. I request that payment or authorized benefits be made on my behalf.

PATIENT/GUARDIAN
SIGNATURE______________________________________DATE________________