Lansing Institute of Urology, PC
1625 Ramblewood Dr.
East Lansing, MI 48823

PATIENT DEMOGRAPHICS

Print Date 1/17/2018

Patient Name:
Address:

Account #: DOB:

Home Phone: Gender:
Account Category: Age:
Social Security #: ____-___-____

Primary Provider:
Referring Procider:

Guarantor Information

Guarantor Name: Home Phone:
Street Address:
City: State Zip Code

Insurance Information

	Name	Address	Phone	Policy #	Group #	Subscriber
1						
2						
3						

Specialist Co-Pay:

Ethnic Group: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other ______________ ☐ Decline to answer

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White

☐ Hawaiian or Pacific Islander ☐ Other __________________ ☐ Decline to answer

Preferred Language: ☐ English ☐ Spanish ☐ Other _________________

Patient Contact Information: Home: Work: Cell:

Email address:

Emergency Contact: Name:__________________________ Phone: _____________________ Relationship: _____________

Employer: Occupation: _____________________________

Address:

City, State, Zip Code: Employer Phone:

How would you prefer to be contacted: ☐ Phone ☐ Mail ☐ Portal Email

How would you prefer to receive reminders from our office? ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Preferred Pharmacy: _________________________ **Location:** _______________ **Pharmacy Phone:** ___________________

MAIL ORDER PHARMACY: ____

Lansing Institute of Urology

A DIVISION OF COMPASS HEALTH

Robert J. Dimitriou, M.D.
Joseph W. Mashni, M.D., F.A.C.S.
Rafid H. Yousif, M.D., M.P.H., F.A.C.S.
Leonard J. Zuckerman, M.D., F.A.C.S.

1625 Ramblewood Dr.
East Lansing, MI 48823
Phone: (517) 324-3700
Fax: (517) 324-4589

LAST NAME: FIRST NAME: DOB:

Insurance Consent

- I authorize the release of any medical information necessary to process my insurance claim.
- I authorize payment of medical benefits to Lansing Institute of Urology, a division of Compass Health, for services rendered when they request that payment be made directly to them.
- I understand that I am ultimately responsible for payment of services that are rendered to me.
- I understand that Lansing Institute of Urology, a division of Compass Health, will bill my insurance company, however I am responsible for any balance that my insurance does not pay.
- I acknowledge that I am responsible for all copayments and/or deductibles.
- I am aware I am responsible for all costs associated with collection agency fees, attorney fees, and court costs associated with the collection of my debt if applicable.

____
Initial

Physician Consent for Medical Treatment

I, the undersigned, hereby authorize and direct Dr. ___________________________________to treat my condition. I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, his assistant, designees or consultants, as may be necessary in the judgment of my physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

____
Initial

____ _____________
Patient Signature **Date**
PRINT FULL NAME: ____

IF PATIENT IS A MINOR- SIGNATURE OF PARENT/LEGAL GUARDIAN: ____

LAST NAME: FIRST NAME: DOB:

HIPAA Acknowledgement of Receipt of Notification of Privacy Practices

I have been made aware of the Compass Health Notice of Privacy Practices. The notice is posted in the waiting area of the Lansing Institute of Urology office. By signing below, I acknowledge that I have been offered this notice, offered a chance to read this notice, and am aware that I can request a copy of this notice to take with me if so desired.

____
Initial

HIPAA Authorization for release of Protected Health Information

If you choose to have your Protected Health Information released to another person, either verbally or in writing, please complete the information below. Initialing the below authorization will not affect your treatment at Lansing Institute of Urology, a division of Compass Health.

I, **_____________________________,** approve Lansing Institute of Urology, a division of Compass Health, to release my health records to the individuals listed below at my request. I understand this authorization is valid for one year from this date and can be revoked or revised at any time with written notice.

Name: ____ **Relationship:** ____________________
Name: ____ **Relationship:** ____________________
Name: ____ **Relationship:** ____________________

_____ **Release my medical information to myself ONLY.**

____
Initial

HIPAA Consent for Use and Disclosure of Your Health Information

By specifying and signing below, you are authorizing Lansing Institute of Urology, a division of Compass Health, and its staff to leave a message on an answering machine, voicemail or with a specified individual, which may include sensitive and/or protected health information.

I **Do____ Do not____** authorize Lansing Institute of Urology, a division of Compass Health, to leave detailed messages regarding my medical condition or treatment on my voicemail.

____
Initial

____ _____________
Patient Signature **Date**
PRINT FULL NAME: ____

IF PATIENT IS A MINOR- SIGNATURE OF PARENT/LEGAL GUARDIAN: ____

Lansing Institute of Urology

A DIVISION OF COMPASS HEALTH

Robert J. Dimitriou, M.D.
Joseph W. Mashni, M.D., F.A.C.S.
Rafid H. Yousif, M.D., M.P.H., F.A.C.S.
Leonard J. Zuckerman, M.D., F.A.C.S.

1625 Ramblewood Dr.
East Lansing, MI 48823
Phone: (517) 324-3700
Fax: (517) 324-4588

PATIENT HISTORY

This is a confidential record and will be kept in your electronic patient chart.

Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ____/____/____ **DATE OF BIRTH ____/____/____**

PRINT PLEASE LAST NAME ___________________________ FIRST NAME ______________________________ M.I. ____

Family Doctor: ___________________________

Reason for seeing the physician on the first visit: ____

Have you been exposed to or currently have TB (tuberculosis)? **Y N**

Have you received the Pneumonia Vaccine in the last 9 years? **Y N Date** _____________

ALLERGIES/REACTIONS TO ANY MEDICATION OR FOOD:

____

____

LIST CURRENT MEDICATIONS *(include over the counter items)*

MEDICATION/DOSAGE	**MEDICATION/DOSAGE**
1.______________________________________	7.______________________________________
2.______________________________________	8.______________________________________
3.______________________________________	9.______________________________________
4.______________________________________	10.______________________________________
5.______________________________________	11.______________________________________
6.______________________________________	12.______________________________________

Do you need to be pre-medicated for surgical or dental procedures? (please circle): Yes No

If yes, please indicate what antibiotic you take: _______________________ Dosage: _____________

PRINT LAST NAME: FIRST NAME: DOB:

PAST SURGICAL HISTORY – Check previous surgeries & provide date *(If nothing marked then NONE APPLY)*

____Appendectomy ___________________________
____ Back Surgery ______________________________
____Bladder Surgery ___________________________
____ Breast Surgery ___________________________
____Cesarean Section __________________________
____Cholecystectomy __________________________
____Colon Surgery ____________________________
____Coronary Artery Bypass ____________________
____Coronary Stent ___________________________
____Cystectomy _______________________________
____Cystoscopy _______________________________
____Gastric Bypass ____________________________
____Green Light PVP ___________________________
____Heart Valve Replacement __________________
____Hernia Repair _____________________________
____Hip Replacement __________________________
____Hydrocele Repair __________________________
____Hysterectomy ____________________________
____Kidney Stone Removal _____________________
____Knee Replacement ________________________
____Laparoscopy _______________________________
____Lithotripsy _______________________________
____Mastectomy _______________________________
____Nephrectomy ______________________________
____Pacemaker Insertion ______________________
____Prostate Surgery __________________________
____Tubal Ligation ____________________________
____Ureteroscopy-Stent ________________________
____Vasectomy _______________________________
____ Other ___________________________________
____
____

PAST MEDICAL HISTORY – Check any previous past medical problems *(If nothing marked then NONE APPLY)*

____Anemia
____Angina
____Arthritis
____Asthma
____BPH
____Cancer _________________
List type of cancer
____Cerebrovascular Accident
____Chronic UTIs
____Congestive Heart Failure
____COPD
____Coronary Artery Disease
____Depression
____Diabetes 1 OR 2 (circle one)
____Diverticular Disease
____GERD
____Gout
____Hepatitis C
____Hypercholesterolemia
____Hyperlipidemia
____Hypertension
____Hypothyroid
____Inflammatory Bowel Disease
____Liver Disease
____Lupus
____Migraine Headaches
____Multiple Sclerosis
____Myocardial Infarction
____Osteoarthritis
____Osteoporosis
____Peptic Ulcer Disease
____Peripheral Vascular Disease
____Renal Disease
____Dialysis
(____Hemo ____Peritoneal)
____Rheumatoid Arthritis
____Seizure Disorder
____Urolithiasis
Other______________________
____
____
____

FAMILY HISTORY ***Indicate*** *what family member has the condition (**FATH, MOTH, SIS, BRO, DAU, SON**)*

Anesthesia Problems___________________________
Bladder Cancer________________________________
Bleeding Disorders_____________________________
Cancer_______________________________________
Diabetes_____________________________________
Heart Problems________________________________
High Blood Pressure____________________________
Kidney Cancer_________________________________
Kidney Disease_________________________________
Kidney Stones__________________________________
Lung Problems__________________________________
Polycystic Kidneys______________________________
Prostate Cancer_________________________________
Stroke_______________________________________
Other____
Unknown History_______________________________

PRINT LAST NAME: FIRST NAME: DOB:

SOCIAL HISTORY: Please Circle Answers

Marital Status: Married Single Divorced Widowed Legally Separated Annulled Life Partner Unknown

Smoking Status: (please circle and answer as appropriate)

Current Every Day Smoker: When did you start smoking? _______________ Packs smoked per day? ______________

Current Some Day Smoker: When did you start smoking? _______________ Packs smoked per day? ______________

Former Smoker: When did you quit? _________ Packs smoked per day _________ How long did you smoke? _________

Never Smoked Smoker, current status unknown Unknown if ever smoked

Do you use Smokeless Tobacco? (please circle): Yes No

How many caffeinated drinks do you have each day? (please circle): 0 1 2 3 4+

Do you drink Alcohol? (please circle): Yes: How much do you drink? ______________ Not Anymore Never Drank

Type of alcohol consumed? (please circle): Beer Liquor Wine

Drinking habits? (please circle): Social Light Moderate Excessive

Do you use recreational drugs? (please circle): Yes No

Have you had a blood transfusion? (please circle): Yes No

REVIEW OF SYSTEMS *(Please circle any symptoms you are currently experiencing)*

Constitutional:	Fever	Chills	Weight Loss	
Eyes:	Blurry vision	Cataracts	Glaucoma	
Ears, Nose, Mouth, Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat	
Cardiovascular:	Chest Pains	Swollen Ankles	Irregular Heartbeat	
Respiratory:	Shortness of Breath	Wheezing	Chronic Cough	Known TB Exposure
Gastrointestinal:	Abdominal Pain	Nausea/Vomiting	Change in Bowels	
Genitourinary:	Incontinence	Painful Urination	Blood in urine	Erectile Dysfunction
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles	
Integumentary/Skin:	Rash	Persistent Itching	Skin Cancer History	
Neurological:	Numbness	Tingling	Dizziness	
Hematologic/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History	
Psychiatric:	Anxiety	Depression		

APPROXIMATE HEIGHT: _____________________ **WEIGHT:** _____________________