BLUE RIDGE UROLOGICAL ASSOCIATES, P.C.

70 Medical Center Circle
Suite 208/212
Fishersville, VA 22939
Phone: 540-932/332-5926

PATIENT INFORMATION:

Last Name: _____ First: _____ Middle: _____

DOB: _____ Age: _____ SSN: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: _____ Spouse/Partner Name: _____

Emergency Contact: _____ Phone: _____

Family / Referring Doctor: _____ Phone: _____

Were You Referred Today? YES _____ NO _____ BY _____

What Pharmacy Do You Use? _____ Phone: _____ Zip: _____

Patient's Employer: _____

Employer's Address: _____ City: _____

State: _____ Zip: _____ Work Phone: _____

GUARANTOR INFORMATION: (Complete Only If Other Than Patient)

Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

REASON FOR YOUR VISIT: _____

ALLERGIES: _____

CURRENT MEDICATIONS: (PLEASE INCLUDE STRENGTH AND HOW MEDICATION IS TAKEN)

_____

_____

_____

_____

ARE YOU TAKING BLOOD THINNERS SUCH AS ASPIRIN, COUMADIN/WARFARIN, NSAIDS, PLAVIX, PRADAXA, ETC? YES NO LIST _____

HAVE YOU HAD A HEART ATTACK IN THE LAST YEAR? YES NO

If YES, date of heart attack _____ Are you taking aspirin or blood thinner as a result? YES NO

HAVE YOU HAD A COLONOSCOPY? YES NO DATE:_____

ARE YOU DIABETIC? YES NO If Yes, date you were diagnosed:_____

HAVE YOU BEEN DIAGNOSED WITH DIABETIC NEUROPATHY? YES NO

DO YOU HAVE HIGH BLOOD PRESSURE? YES NO If Yes, date diagnosed:_____

HAVE YOU RECEIVED THE PNEUMOCOCCAL VACCINATION? YES NO

If YES, who administered it and when? _____

SURGICAL HISTORY: (PLEASE LIST ALL SURGERIES AND DATES)

_____

_____

_____

_____

_____

PERSONAL MEDICAL HISTORY: (CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING)

Anemia

Anxiety

Arthritis

Asthma

Blood Clots

Bronchitis

Cerebrovascular Accident

Constipation

COPD

Depression

Diabetes

Diverticulitis

Gallstones

GERD

Glaucoma

Heart Attack

Heart Disorder/Disease

Hepatitis/Liver Problems

High Blood Pressure

High Cholesterol

Kidney Stones

Migraines

Pacemaker

Pneumonia

Seizures

Shortness of Breath

Thyroid Disorder/Disease

Frequent Urination

PERSONAL MEDICAL HISTORY: (CONTINUED)

Cancer (If so, what type)

_____

List Any Other Medical Condition(s) _____

_____

_____

Have You Ever Had Any Problems With Anesthesia? _____

SOCIAL HISTORY: (Please Circle Correct Response)

Marital Status: Married Single Divorced Widowed Separated Annulled Life Partner

Smoking Status: Current Every Day Smoker Yes How many? _____ No

Current **Some** Day Smoker Yes How many? _____ No

Former Smoker Yes When did you quit? _____ No/Never a Smoker

Smokeless Tobacco: Yes No

Do You Drink Alcohol? Yes Which type? Beer Wine Liquor How much? _____

Not Anymore When did you quit? _____ Never drank _____

Do You Use Recreational Drugs? No Yes If Yes explain: _____

How Many Caffeinated Drinks Do You Have Each Day?: _____

Race: White Black/African American Hispanic/Latino Other: _____

Ethnicity: Hispanic/Latino Yes No

Have You Ever Had A Blood Transfusion? Yes No

FAMILY HISTORY: (INCLUDE PARENTS, SIBLINGS, AND GRANDPARENTS ONLY)

CONDITION:	WHO?
Anemia	_____
Anxiety	_____
Arthritis	_____
Asthma	_____
Blood Clots	_____
Bronchitis	_____
Cerebrovascular Accident	_____

FAMILY HISTORY CONTINUED:

CONDITION:	WHO?
Constipation	
COPD	
Depression	
Diabetes	
Diverticulitis	
Gallstones	
GERD	
Glaucoma	
Heart Attack	
Heart Disorder/Disease	
Hepatitis/Liver Problems	
High Blood Pressure	
High Cholesterol	
Kidney Stones	
Migraines	
Pacemaker	
Pneumonia	
Seizures	
Shortness of Breath	
Thyroid Disorder/Disease	
Frequent Urination	

Cancer (If so, what type)

Blue Ridge Urological, P.C.

Patient's Consent for Provider to Disclose PHI to Authorized Persons

1. **Authorization to Disclose PHI (Protected Health Information).** I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.

2. **Persons to Whom Disclosure May be Made.** Provider may disclose my PHI to the following persons:

Name	Relationship, If Any
_____	_____
_____	_____
_____	_____

3. **Purpose of Disclosure**. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

4. **Expiration of Authorization.** This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

5. **Conditioning of Treatment**. Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

6. **Redisclosure by Recipient.** I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.

7. **Acknowledgment of Reading and Agreement.** I have read and understand this authorization.

_____ _____

Patient Name or Representative Date

If a Representative Signs, state the Representative's Authority:

_____

Blue Ridge Urological, P.C.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

_____ _____

PATIENT SIGNATURE
Or Personal Representative

DATE

BLUE RIDGE UROLOGICAL, P.C.

70 MEDICAL CENTER CIRCLE, SUITES 208 & 212

FISHERSVILLE, VA 22939

PHONE (540) 332-5926 FAX (540) 332-5930

C. BUCKLEY GILLOCK, MD

WILLIAM R. JONES III, MD

SAM D. GRAHAM JR, MD

BRIAN C. STISSER, MD

EMILY M. GREENE, PA-C

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, (patient's name) _____ authorize the release of medical information FROM doctors, C. Buckley Gillock, William R. Jones III, Sam D. Graham Jr, Brian C. Stisser, and Emily M. Greene, PA-C.

TO THE FOLLOWING PHYSICIAN OR HOSPITAL:

_____

_____

_____

_____

_____

Signature of Patient: _____

Date: _____

Patient's date of birth: _____

Witness: _____

Blue Ridge
Urological, PC

You agree, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. I/we have read this disclosure and agree that Blue Ridge Urological may contact me/us as described above.

Signature: _____

Date: _____

I do not agree to be contacted by any telephone numbers associated with my billing account.

Signature: _____

Date: _____

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