

Date _____

Patient Information

Patient Name: _____

Date of Birth: ____/____/____ Marital Status? S M D W Employed? Y N

Student: Y N Social Security # ____-____-____ Have you been to our office? Y N

Street Address: _____ APT #: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) - ____ - ____ Business Phone: (____) - ____ - ____

Employer Name: _____

Address: _____

Family Physician: _____

Address: _____

Phone Number: (____) - ____ - ____

Referred By: _____

Address: _____

Phone Number: (____) - ____ - ____

Spouse/Guardian's Name: _____ Date of Birth: ____/____/____

I request that payment of authorized Medigap benefits be made payable to Western Main Line Urology.

Signature: _____

All professional services rendered are the responsibility of the patient. Your insurance claim will be filed for you with your insurance carrier for covered services. The patient is responsible for all fees regardless of insurance coverage. All payments are due at the time of service unless other financial arrangements have been made in advance. I hereby authorize payment directly to Western Main Line Urology. The group insurance benefits otherwise payable to me. Any balance is my responsibility.

Date: ____/____/____ Signature: _____

I hereby authorize release of medical information to my insurance carrier regarding this or any future claim.

Date: ____/____/____ Signature: _____

Review of Systems

Do you now have or have you had any problems related to the following systems? Circle **Yes** or **No**.
Please explain any Yes answers in the space to the right.

Genitourinary

Frequent urination	Y	N
Urgent urination	Y	N
Pain on urination	Y	N
Dribbling of urine	Y	N
Lower abdominal pain	Y	N

Genitourinary (continued)

Pain in the testicles	Y	N
Back pain	Y	N
Fever	Y	N
Blood in urine	Y	N
Other	_____	

Gastrointestinal

Abdominal Pain	Y	N
Constipation	Y	N
Diarrhea	Y	N
Other	_____	

Cardiovascular

Chest Pain	Y	N
Varicose veins	Y	N
High Blood Pressure	Y	N
Other	_____	

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other	_____	

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other	_____	

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	y	N
Other	_____	

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other	_____	

Ear / Nose / Throat / Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other	_____	

Hematologic / Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other	_____	

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness / Tingling	Y	N
Other	_____	

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other	_____	

Endocrine

Excessive thirst	Y	N
Too hot / cold	Y	N
Tired / Sluggish	Y	N
Other	_____	

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you ever considered suicide?	Y	N
Other	_____	

Allergic / Immunologic

Hay Fever	Y	N
Other	_____	

Date _____

Name: _____ Age: _____

Chief complaint: _____

Symptoms: _____

When did symptoms begin? _____
 Have you ever had same or similar symptoms? _____
 If so, when? _____
 Is this a work injury? _____
 Date of injury: _____

If disabled from work due to this illness, give date you last worked: _____
 If symptoms resulted from a motor vehicle accident, give date of accident: _____

Past Medical History: *Operations/Surgeries & Year*

Serious Injuries or Accidents:

Illnesses:

List Current Medications/Treatments:

Allergies to Drugs, Foods, or Pollens:

Family History: *Age & Illness or Cause of Death*

Father: Living _____
Deceased _____

Mother: Living _____
Deceased _____

Living Brothers and Sisters: _____

Deceased Brothers and Sisters: _____

Children: Yes No
If Yes, number living: _____
Number deceased: _____

In your family is there a history of:

DiabetesNo Yes
 Heart AttackNo Yes
 StrokeNo Yes
 Cancer or LeukemiaNo Yes
 HepatitisNo Yes
 Bleeding DisorderNo Yes
 Kidney StonesNo Yes

Miscellaneous History:

Cigarettes (packs per day): _____
 Coffee, tea, or Coke (cups per day): _____
 Alcoholic beverages (drinks per day): _____

Date _____

WESTERN MAIN LINE UROLOGY

GREGORY M. THOMPSON, M.D., F.A.C.S.

Adult & Pediatric Urology

Paoli Memorial Medical Bldg., Suite 333

Paoli, Pennsylvania 19301

Telephone: 610-644-9600

Fax: 610-644-0804

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND
AUTHORIZATION TO RELEASE HEALTH INFORMATION**

By signing below, I acknowledge receipt of the Notice of Privacy Practices of Gregory M. Thompson, M.D. In addition, by signing below, I authorize Gregory M. Thompson, M.D. to disclose my health information in conformance with the provisions of the Notice of Privacy. I also authorize Gregory M. Thompson, M.D. the right to communicate test results, details of my medical condition and any other issues related to medical care with the following people:

Signature: _____ Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT (to be completed only if no signature is obtained.)

No acknowledgement of receipt of Privacy Practices was obtained from the patient because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining the acknowledgement

_____ Other (please specify)

Signature of Gregory M. Thompson, M.D. Representative:

_____ Date: _____