# TULANE UROLOGY @ GARDEN DISTRICT

Patient Name: _____ Date: _____

**NEW PATIENT INFORMATION: Medical History**

**Reason for your visit today:**

_____

_____

_____

**Current Medications:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**Are you currently taking a blood thinner?** ❑ NO ❑YES- SEE BELOW

❑ Aspirin ❑ Plavix ❑ Coumadin (Warfarin) ❑ Xarelto ❑ Fish Oil ❑ Vitamin E

**Do you have any allergies?** ❑ No ❑ Yes:_____

**Are you allergic to latex?** ❑ No ❑ Yes

**Do you drink caffeine (soda, coffee)?**

❑ No

❑ Yes: How many drinks per day? _____

**Do you smoke or use tobacco?**

❑ No

❑ Previously Smoked Quit for how many years?_____

❑ Yes- How many packs per day?_____ For how many years? _____

**Do you drink alcohol?**

❑ No

❑ Yes: How many drinks per day? _____

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**Family Medical History:**
Please provide us with the conditions your family members have had

| CONDITION | FAMILY MEMBER | CONDITION | FAMILY MEMBER |
|---|---|---|---|
| ❑ Heart Disease | | ❑ Prostate Cancer | |
| ❑ Diabetes | | ❑ Cancer Type- | |
| ❑ Stroke | | ❑ High Cholesterol | |
| ❑ Alzheimer's | | ❑ Parkinson's | |
| ❑ Heart Attack | | ❑ Kidney Disease | |
| ❑ High Blood Pressure | | ❑ Dementia | |
| ❑ Other: | | | |

**Past Surgical History:**

| Name of Surgery | Date of Surgery (Year) |
|---|---|
| | |
| | |
| | |

**Past Medical History:** (conditions you have or had)

❑ Heart Disease
❑ Heart Attack
❑ Diabetes
❑ Stroke
❑ Dialysis
❑ Cancer- Type _____
❑ High cholesterol
❑ HIV/ AIDS
❑ High Cholesterol
❑ Hepatitis A / B / C
❑ Liver Disease
❑ Prostate Cancer
❑ High Blood Pressure
❑ Depression
❑ Epilepsy/Seizures

❑ Other: _____

# TULANE UROLOGY @ GARDEN DISTRICT

**Review of Systems**
Please select only the following that apply to you

**Psychological:**
- ❑ Depression
- ❑ Anxiety
- ❑ Suicidal Thoughts

**Hemo/Lymph:**
- ❑ Swollen Glands
- ❑ Blood Clotting Problems
- ❑ HIV

**Respiratory:**
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Frequent Cough
- ❑ Coughing up blood
- ❑ Tuberculosis
- ❑ Wheezing

**ENT:**
- ❑ Sinus Problems
- ❑ Vertigo
- ❑ Hearing loss

**Musculoskeletal:**
- ❑ Muscle or joint pain
- ❑ Back Pain
- ❑ Arthritis

**Skin:**
- ❑ Rash/Skin Lumps
- ❑ Psoriasis

**Cardiovascular:**
- ❑ Heart Trouble
- ❑ High Blood Pressure
- ❑ Chest pain or discomfort
- ❑ Irregular Heart Beat
- ❑ Heart Murmur

**Gastrointestinal**
- ❑ Abdominal Pain
- ❑ Nausea/Vomiting

**Endocrine:**
- ❑ Excessive Thirst
- ❑ Tired/Sluggish
- ❑ Too Hot/Cold

**Neurological**
- ❑ Fainting
- ❑ Dizziness
- ❑ Numbness/Tingling
- ❑ Tremors
- ❑ Seizures
- ❑ Paralysis/ Weakness

**Eyes:**
- ❑ Blurry or double vision
- ❑ Glaucoma
- ❑ Cataracts

**General:**
- ❑ Weight loss or gain
- ❑ Fatigue
- ❑ Sleep Apnea
- ❑ Fever or chills
- ❑ Headaches
- ❑ Other: _____

Patient Name  Signature  Date

# Tulane University Medical Group

## Notice of Privacy Practices

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of the Tulane University Medical Group Notice of Privacy Practices.

Signature_____ Date_____

Print Patient's Name_____

If not signed by the patient, please indicate relationship:_____

Print Name_____ Witness_____

# Tulane University Medical Group
# CONSENT AND RELEASE

**ASSIGNMENT OF BENEFITS:** I authorize direct payment to Tulane University Medical Group (TUMG), of all medical benefits, settlements, or judgments applicable to my treatment by TUMG physicians and other clinicians at the hospital or clinic. This authorization is applicable to all future charges and fees from, and including, this day forward, unless revoked in writing by me. I understand that I am personally responsible for payment of all fees applicable to my treatment by TUMG physicians at the hospital or clinic, including copayments, deductibles, and fees for non-covered services, irrespective of other insurance coverage or other parties' responsibility to me for such fees. If unpaid balances are overdue and are referred for collection, I agree to pay the attorney's fees, court costs, and/or collection agency fees associated with collection.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, ACCEPTS THE TERMS THEREOF, AND HAS RECEIVED A COPY THEREOF.

**RELEASE OF INFORMATION:** I authorize TUMG and/or its physicians and other clinicians to disclose all or part of my medical or billing records to any insurance carrier or persons employed by such carrier for the purpose of collecting insurance benefits and auditing claims, so long as I am listed on this account as having coverage with such carrier. This authorization includes release of information to group health plans for group insurance coverage, workman's compensation carriers, and welfare agencies, if applicable to my claim for treatment. I hereby indemnify and release TUMG and its physicians and clinicians from any and all responsibility relative to the release of such information. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records: decreasing the time needed to access my information; aggregating and comparing mu information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

| PATIENT NAME | DATE OF BIRTH | PATIENT SIGNATURE |
|---|---|---|
| NAME OF AUTHORIZED AGENT, IF ANY | SIGNATURE – IF SIGNED BY AUTHORIZED AGENT | RELATIONSHIP TO PATIENT |
| WITNESS NAME | WITNESS SIGNATURE | DATE OF SIGNING TIME |

**RX ELIGIBILITY CONSENT -** By signing this consent form you are agreeing that Tulane University Medical Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I hereby provide informed consent to Tulane University Medical Group to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

INITIAL _____

**CONSENT FOR TREATMENT** DATE _____ TIME _____

I, OR _____ FOR _____ KNOWING THAT (I AM/HE OR SHE IS) SUFFERING FROM A CONDITION REQUIRING DIAGNOSIS AND/OR MEDICAL OR SURGICAL TREATMENT, DO HEREBY VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC PROCEDURES AND HOSPITAL, MEDICAL, AND SURGICAL CARE AS NECESSARY IN THE JUDGMENT OF PHYSICIAN(S) IN CHARGE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE ME AS TO THE RESULTS OF EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE TULANE UNIVERSITY MEDICAL GROUP TO RETAIN OR DISPOSE OF ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY DURING MY TREATMENT, AND TO USE SUCH SPECIMENS OR TISSUES FOR SCIENTIFIC, EDUCATIONAL, OR RESEARCH PURPOSES, TO THE EXTENT THAT SUCH SPECIMENS AND TISSUES ARE NOT KEPT AT TULANE UNIVERSITY HOSPITAL AND CLINIC.

WITNESS _____ SIGNATURE _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)

**REFUSAL OF CONSENT FOR TREATMENT**

I, _____ REFUSE TO CONSENT TO _____

_____ UPON _____

_____ I HAVE BEEN ADVISED OF THE CONSEQUENCES AND RISKS OF SUCH REFUSAL, AND HEREBY RELEASE THE PHYSICIANS, CLINICIANS, AND TULANE UNIVERSITY MEDICAL GROUP FROM LIABILITY FOR INJURIES ARISING FROM SUCH REFUSAL.

WITNESS _____ SIGNATURE _____
(PATIENT OR PERSON AUTHORIZED TO CONSENT RELATIONSHIP)