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 Brett C. Hill, M.D.
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H. Jeffrey Deeths, M.D., F.A.C.S.
 Emeritus

Thank you for choosing The Urology Center, P.C. for your urological care:
 Our goal is to make your visit as pleasant as possible.

Your appointment date is: _____

Time: _____

Doctor: _____

Main Office
 111 South 90th St.
 Omaha, NE 68114
 (402) 397-9800
 (800) 882-4770

Procedure Room
 105 South 90th St.
 Omaha, NE 68114
 (402) 397-9800

Midlands Office
 401 East Gold Coast Rd. #331
 Papillion, NE 68046
 (402) 592-5567

Bergan Office
 7710 Mercy Rd. #608
 Omaha, NE 68125
 (402) 399-8166

Columbus Office
 4508 38th St. #128
 Columbus, NE 68601
 (402) 562-8114

Lakeside Office
 16909 Lakeside Hills Ct. #407
 Omaha, NE 68130
 (402) 330-4474

Please arrive 15 minutes prior to your appointment

It will save your time as well as ours if you bring the following items with you on your first visit.

1. **PATIENT HISTORY FORM** – Filling out the enclosed form prior to your appointment will save you time at the office and will often allow you to provide more accurate information.
2. **PATIENT INFORMATION FORM** – The other enclosed form gives us the information necessary to keep in contact with you, your referring doctor, and your insurance company.
3. **X-RAYS AND LAB REPORTS** – In order to avoid duplicate testing, it is very helpful if you can bring with you any pertinent x-rays or lab test results that may have been obtained by your referring doctor.
4. **HMO REFERRAL** – If you belong to an HMO plan and need a referral please be sure to bring it with you. It is against HMO rules to see you if you don't have a referral.
5. **INSURANCE CARD** – We will need to make a copy of your card for our records.
6. **ADVANCED MEDICAL DIRECTIVE** – If you have executed an advanced medical directive or healthcare power of attorney please bring a copy with you.

If we can do anything to make your visit more pleasant, please let us know.

The Urology Center, P.C.

PATIENT INFORMATION

Patient Name: _____
Male Female

Address: _____

Home Phone: _____
Ok to leave a message Yes or No

Work Phone: _____
Ok to leave a message Yes or No

Cell Phone: _____
Ok to leave a message Yes or No

Date of Birth: _____

Social Security Number: _____

Referring Dr: _____

Family Dr: _____

Spouse/Parent: _____

PERMISSION TO RELEASE INFORMATION

TO: Spouse

Other: Name: _____

Emergency

Contact: _____

Emergency Phone: _____

INSURANCE INFORMATION

Primary

Insured's Name Date of Birth Insured's Employer, Employer Address & Phone Number

Secondary

Insured's Name Date of Birth Insured's Employer, Employer Address & Phone Number

Date

RESPONSIBLE PARTY INFORMATION

Guarantor: _____

Address: _____

Home Phone: _____

Work Phone: _____

EMPLOYER INFORMATION

Employer Name: _____

Employer

Address: _____

Employer

Phone: _____

DO YOU HAVE ANY KNOWN ALLERGIES?

Yes No

LIST KNOWN ALLERGIES:

AMERICAN RECOVERY AND REINVESTMENT ACT, ENACTED February 2009

Preferred Language: _____

Race: American Indian or Alaska Native

Black or African American

Caucasian

Asian

Native Hawaiian or Other Pacific Islander

Other

Ethnicity: Hispanic or Latino

Not Hispanic or Latino

The Urology Center, P.C. – Authorization Form

A. Notice of Privacy Practices

The Policies and Procedures of The Urology Center, P.C. are designed to comply with the Health Insurance Portability and Accountability Act of 1996. The Urology Center, P.C. will release your protected health information to your doctors, hospitals or insurance companies for treatment, payment and operation. The Urology Center, P.C. Notice of Privacy Practices are posted in the reception area and are available at the front desk.

B. Authorization To Treat

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving laboratory, pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

C. Assign of Insurance Benefits

I hereby assign all medical and /or surgical health insurance benefits, to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance.

D. Patient Rights and Responsibilities

The Urology Center, P.C. has established a Patient's Bill of Rights, I agree that I have received and understand my rights as a patient.

E. Advance Directive

Regardless of any advance directives set forth in a living will, health care power of attorney or other written statement, any unexpected medical emergency, in this facility, will be managed with resuscitative or other stabilizing measures followed by a transfer to a hospital's emergency department.

F. Disclosure of Ownership

The Urology Center, P.C. including our Ambulatory Surgery Center, is owned and operated by Drs. Konigsberg, Kroeger, Gordon, Morton, Koukol, Longo, Lim, Jepson, Leu, Donovan, Richardson and Hill. Any services that you receive at this location are a part of the operations of The Urology Center, P.C.

G. Medicare Coordination of Benefits Assessment

Medicare requires that we ask the following questions of all our patients so that we can comply with Medicare rules and regulations. We appreciate your time in completing these questions.

- | | | | |
|--|------------|-----------|-----------|
| 1. Are you or your spouse currently employed? | YES | OR | NO |
| If yes then: | | | |
| Do you have group health coverage based on your own or a spouse's current employment? | YES | OR | NO |
| 2. Are you entitled to Medicare because of disability or End Stage Renal Disease? | YES | OR | NO |
| 3. Is this illness or injury the result of an automobile accident or other injury? | YES | OR | NO |
| 4. Is this illness or injury the result of an accident or illness that occurred at work: | YES | OR | NO |
| 5. Has treatment and payment for this accident or illness been authorized by the Veteran's Administration? | YES | OR | NO |
| 6. Are you entitled to any benefits under the Federal Black Lung Program? | YES | OR | NO |

The undersigned patient or patient's guardian hereby acknowledge that I have read, understand and agree to conditions set forth in the:

- A. Notice of Privacy Practices
- B. Authorization to Treat
- C. Assignment of Benefits
- D. Patient Rights and Responsibilities
- E. Advance Directive
- F. Disclosure of Ownership

As a Medicare recipient, if applicable, I have completed Section G accurately and to the best of my ability.

Printed Patient Name

Account Number

Signature

Date

Urology Center, P.C.

Patient History Form

Date: _____

Date of Birth: _____

Name: _____

Age: _____

Past Medical History

Please check any illnesses you have or have had in the past:

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Neurogenic Bladder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Degenerative Lumbar Disk Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Benign Prostatic Hypertrophy (BPH)
or Enlarged Prostate | <input type="checkbox"/> Dementia/Alzheimers | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Depression | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Bleeding Tendency Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Cancer – Bladder | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cancer – Breast | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Cancer – Cervical | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Radiation Cystitis |
| <input type="checkbox"/> Cancer – Colon | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Renal Insufficiency |
| <input type="checkbox"/> Cancer – Esophageal | <input type="checkbox"/> GERD/Acid Reflux | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cancer – Kidney | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Spina Bifida or
Myelomeningocele |
| <input type="checkbox"/> Cancer - Leukemia/Lymphoma | <input type="checkbox"/> Gout | <input type="checkbox"/> STD |
| <input type="checkbox"/> Cancer – Lung | <input type="checkbox"/> Heart Attack/MI | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer – Other | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer – Prostate | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Transient Ischemic Attack |
| <input type="checkbox"/> Cancer – Skin | <input type="checkbox"/> High Blood Pressure/Hypertension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer – Testicular | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Urethral Stricture Disease |
| <input type="checkbox"/> Cancer – Uterine | <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Valvular Heart Disease or
Heart Murmur |
| <input type="checkbox"/> Cardiac Arrhythmia | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Irritable Bowel Syndrome | |
| <input type="checkbox"/> Chron's/Ulcerative Colitis | <input type="checkbox"/> Kidney Infection | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Liver disease/Jaundice | |
| | <input type="checkbox"/> MRSA | Other: _____ |

Past Surgical History

Please list all of your previous operations and hospitalizations. Give dates and locations if known.

If female, how many pregnancies have you had? _____ How many miscarriages? _____

Family History

Please check each medical concern that has occurred in your blood relatives:

DISEASE	Father	Mother	Sister	Brother		Father	Mother	Sister	Brother
Diabetes					High Blood Pressure				
Kidney Disease					Heart Disease				
Kidney Stones					Bedwetting				
Cancer					Nervous Disorder				
Bleeding Tendency					Stroke				
					Tuberculosis				

Is your father alive? ___ Yes ___ No Age/Age at death: ___ Present Health/Cause of Death _____

Is your mother alive? ___ Yes ___ No Age/Age at death: ___ Present Health/Cause of Death _____

If you are a male, do you have any relatives who have had prostate cancer? ___ Yes ___ No

If so, which relatives? ___ Father ___ Brother(s) ___ Other _____

If you know of any other medical conditions that run in your family, please list them here:

PLEASE COMPLETE THE QUESTIONS ON THE BACK OF THIS FORM.

Name: _____

Social Habits History

Do you smoke cigarettes? ___ Yes ___ No If yes, how many packs per day? ___ For how long? _____

Did you smoke cigarettes previously and quit? ___ Yes ___ No If yes, how many packs per day? ___ For how long? _____ When did you quit? _____

Do you use any other form of tobacco? ___ Yes ___ No If yes, what kind? _____

Do you drink alcohol? ___ Yes ___ No If yes, how much do you drink in an average week? _____

Do you drink caffeine? ___ Yes ___ No If yes, how many per day? _____

Do you use any other drugs? ___ Yes ___ No If yes, what kind? _____

Allergies

Medication

Reaction

___ Sulfa

___ Penicillin

___ Iodine (IV Contrast/Dye)

___ Latex

Other: _____

Other: _____

Medication

Reaction

Other: _____

Other: _____

Other: _____

Other: _____

Other: _____

Other: _____

Other (Please Specify): _____

No Drug Allergies _____

Medications

Please bring your current medication list to every visit to The Urology Center PC

Please list or attach a list of all the medications you are currently taking, including prescription, over the counter and herbal supplements:

Drug, medication or herbal	How often taken	Dosage (mg, mcg, IU, ect.)

Your local Pharmacy: _____

Your mail order Pharmacy: _____

Height and Weight

Height: _____

Weight: _____

Name: _____

Date of Birth: _____

Chief Complaint

What is the main reason you came to the Urology Center at this time? _____

Urologic Symptoms

Please check symptoms you have now:

- | | |
|---|--|
| <input type="checkbox"/> blood in urine | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> burning or pain with urination | <input type="checkbox"/> phimosis |
| <input type="checkbox"/> change in voiding habits | <input type="checkbox"/> slow urinary stream |
| <input type="checkbox"/> dysuria | <input type="checkbox"/> stress incontinence |
| <input type="checkbox"/> flank pain | <input type="checkbox"/> trouble starting stream |
| <input type="checkbox"/> frequent urination - daytime | <input type="checkbox"/> trouble with erections |
| <input type="checkbox"/> frequent urination - night | <input type="checkbox"/> urethral discharge |
| <input type="checkbox"/> incomplete bladder emptying | <input type="checkbox"/> urgency |
| | <input type="checkbox"/> vaginal discharge |

Review

Reviewed by: _____ M.D. Date: _____

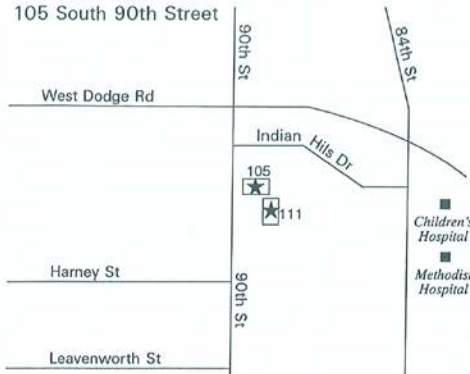
The Urology Center, PC

1

Main Office and Surgery Center

111 South 90th Street
Omaha, Nebraska 68114
(402) 397-9800

Procedure Room
105 South 90th Street



2

Bergan Office

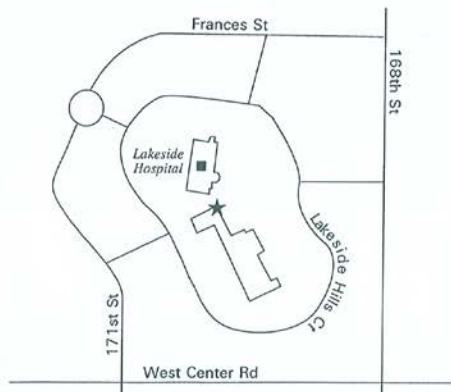
7710 Mercy Road, #608
Omaha, Nebraska 68124
(402) 399-8166
Located in Medical Building South



3

Lakeside Office

16909 Lakeside Hills Court, #407
Omaha, Nebraska 68130
(402) 330-4474
Located in Professional Center North



4

Midlands Office

401 East Gold Coast Road, #331
Papillion, NE 68046
(402) 592-5567
Located in Medical Office Building

