# LAKEVIEW CENTER FOR UROLOGY
# REGISTRATION FORM

Please PRINT and complete ALL sections below.

Date:

## PATIENT INFORMATION

| Last Name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status: (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Date of Birth: | Social Security: | | Sex: ❑ M ❑ F |
|---|---|---|---|

| Street address: | Cell Phone: ( ) | Home Phone: ( ) |
|---|---|---|

| P.O. Box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | |
|---|---|---|

Referred By: Email :

## INSURANCE INFORMATION

Please give your insurance card to the front desk.

| Person Responsible for Bill: | Birth Date: / / | Address (if different): | Home Phone: ( ) |
|---|---|---|---|

Is this person a patient here? ❑ Yes ❑ No

Is this patient covered by insurance? ❑ Yes ❑ No

Please Indicate Primary Insurance:

| Subscriber's Name: | Subscriber's Social Security: | Birth Date: / / | Group No: | Policy No: | Co-Pay: $ |
|---|---|---|---|---|---|

Patient's Relationship to Subscriber:

| Name of Secondary Insurance (if applicable): | Subscriber's Name: | Group No: | Policy No: |
|---|---|---|---|

Patient's Relationship to Subscriber:

## IN CASE OF EMERGENCY

| In Case of Emergency Notify: | Relationship to Patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

**Please Read & Sign Below:**

I directly assign all Medical/Surgical benefits to Fawad S. Zafar, M.D. & understand that I am financially responsible for all charges whether or not paid by insurance. I understand that payment is due within 30 days of receiving an invoice. I further understand that Lakeview Center for Urology will not check my insurance benefits.

I hereby authorize Dr. Zafar to release all information necessary to secure the payments of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

***Patient Signature*** ***Date***

# Medical History Questionnaire


## Lakeview Center for Urology

Fawad Zafar, MD

1000 73rd St. Ste. 17 West Des Moines, IA 50265


Patient Name: _____

DOB: _____ Weight: _____ Height: ____ft ____in

Chief Complaint/ Reason for visit: _____

Primary Care Doctor: _____

Drug Allergies/Sensitivities: _____

Pharmacy & Location: _____

| CURRENT MEDICATIONS |
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| MEDICAL HISTORY | |
|---|---|
| | |
| ❑ HIV/AIDS | ❑ Bladder Cancer |
| ❑ Diabetes Type 1 | ❑ Kidney Cancer |
| ❑ Diabetes Type 2 | ❑ Prostate Cancer |
| ❑ Kidney Stones | ❑ Testicular Cancer |
| ❑ Bladder Infections | ❑ Erectile Dysfunction |
| ❑ Prostate Infections | ❑ Depression |
| ❑ Prostate Enlargement | ❑ Infertility |
| ❑ High Blood Pressure | ❑ Anxiety |
| ❑ Kidney Disease | ❑ Cholesterol |
| ❑ Glaucoma | ❑ Other: |

| SURGICAL HISTORY | DATE OF SURGERY |
|---|---|
| ❑ Colonoscopy | |
| ❑ Pneumococcal Vaccine | |
| ❑ Other: | |
| | |
| | |
| | |

| FAMILY HISTORY | IF YES, WHO? |
|---|---|
| ❑ Kidney Cancer | |
| ❑ Bladder Cancer | |
| ❑ Prostate Cancer | |
| ❑ Kidney Disease | |
| ❑ Kidney Stones | |
| ❑ High Blood Pressure | |
| ❑ Diabetes | |
| ❑ Heart Disease | |
| ❑ Other: | |
| | |

| SOCIAL HISTORY- Please Circle |
|---|
| **Marital Status** Married Single Divorced Widowed Life Partner |
| **Smoking Status:** Current smoker- Packs per day? |
| Former smoker - When did you quit? |
| Never a smoker |
| **How many caffeinated drinks do you have each day?** |
| **Do you drink alcohol?** No Yes - How much? |
| **Do you use recreational drugs?** No Yes - What? |
| **Have you had a blood transfusion?** No Yes - When? |
| **Race/ Ethnicity:** |
| **Prefered Language:** |

Signature: _____ Date: _____

# HIPAA / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:

Patient's Date of Birth:

**Notice to Patient:**
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

*(To Be Completed by Patient or Patient's Representative)*

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations. This information may be released to:

____ Spouse: _____
____ Children: _____
____ Other: _____

_____ I do not authorize the release of my information.

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

## MESSAGES

Please leave messages on: _____

If unable to reach me:

_____ You may leave a detailed message

_____ Please leave a message asking me to return your call

_____
Employee Signature

# Outside Services for Radiology and Lab

Lakeview Center for Urology
Fawad Zafar, MD
1000 73rd St. Suite 17 West Des Moines, IA 50265
515-277-8900

This office uses outside services for radiology and laboratory testing, such as urine culture, cytology, prostate biopsy, vas deferens segments, any lesions removed, bladder biopsy, cultures of any kind, biopsies of any kind, specimens of any kind and blood work.

These outside services will be billed and filed to your insurance by the respective offices where the services are provided.

**PLEASE NOTE:** This office uses Iowa Pathology Laboratory &/or Quest Diagnostic for lab work. Radiology services are done at various locations.

If your insurance requires a specific facility for lab work or imaging please notify our office staff beforehand.

All patients are responsible for copays or any amount applied to their deductible.

Thank you,

Lakeview Center for Urology

_____ _____

Patient Signature Date