Robert T. Ryan, III, MD 1339 E Court, Ste. 220 Seguin, TX 78155 Ph: 830-379-8491 Fax: 830-386-0395

Patient Information

Last Name_____ First Name_____ Middle Name_____

Social Security Number_____-____-_____ Date of Birth____/____/_____ Age_____

Race: ☐White ☐Black/African American ☐Hispanic ☐Other

Ethnic Group: ☐Caucasian ☐Hispanic ☐African American ☐Asian ☐American Indian ☐Other

Marital Status: Single / Married / Divorced / Widowed

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Contact Number: ☐Home ☐Work ☐Cell

Employer: _____ Occupation: _____

Work Address: _____

Referred By: _____ Family Doctor: _____

Responsible Party if Different From Above:

Name: _____Employer: _____

Mailing Address: _____

Home Phone: _____ Social Security Number_____-____-_____ Date of Birth____/____/_____

Emergency Contacts:

Name: _____Address: _____

Home Phone: _____ Cell Phone: _____Relationship:_____

Name of Pharmacy: _____ Phone Number: _____

This form is intended to aid your physician in evaluating your past medical history. Please answer all questions as best you can and as briefly as possible. If you have questions, please ask the nurse, and give her the form when completed.

Medical History: Have you ever had any of the following medical problems? Please circle if applicable.

Arthritis	☐	COPD	☐	Thyroid	☐
Heart Arrhythmia	☐	Asthma	☐	Cancer -Type:_____	☐
Diabetes	☐	Kidney Stones	☐	Gout	☐
Seizure Disorder	☐	Renal Disease	☐	High Cholesterol	☐
Gallstones	☐	Congestive Heart Failure	☐	Stroke	☐
Heart Attack	☐	Peptic Ulcer Disease	☐	Paralysis	☐
Heart Disease	☐	High Blood Pressure	☐	Dialysis	☐☐

Other: _____

_____

Surgery History: Please circle if applicable; also list **date** and **name of hospital and/or surgeon,** if known.

Appendix	☐	_____
Bone/Joint	☐	_____
Gallbladder	☐	_____
Heart	☐	_____
Hernia (what type)	☐	_____
Kidney	☐	_____
Bladder Repair/Lift	☐	_____
Thyroid	☐	_____
Hysterectomy	☐	_____
Lung	☐	_____
Artery/Vein	☐	_____

Other: _____

_____

Medications: Please list all current medicines **you** take, prescription and/or over the counter.

	Medicine	**How often**	**Dosage**	**What is it for?**
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____
11.	_____	_____	_____	_____
12.	_____	_____	_____	_____

Reason for the Visit Today:

_____

_____

_____

Do you take Aspirin daily? _____ List any Allergies to medicines:_____

Habits: (per day)

Tobacco (how much) _____How long?_____

Type: Cigarettes / Cigars / Smokeless

Alcohol (how much) _____ Coffee/ tea (how much)_____

Drugs not prescribed to you:_____

Special Diet?_____ What kind?_____

OB-Gyn: (females only)

No. of pregnancies: _____

Miscarriages: _____

Living Births: _____

Premature Births: _____

Did any child weigh over 9 lbs? _____

Family History:

Father:	Living _____	Age _____	**Mother:**	Living _____	Age _____
	Deceased _____	Age _____		Deceased _____	Age _____
	If living, state of health_____			If living, state of health_____	
	_____			_____	
	Cause of death_____			Cause of death_____	

Please list any medical problems associated with the immediate family members listed below, if known.

Brothers: _____

Sisters: _____

Sons: _____

Daughters: _____

★ Attention ★

I hereby assign payment directly to Guadalupe Regional Medical Group (Guadalupe Urology) for medical and/or surgical benefits, if any, otherwise payable to me for services provided at the clinic (not to exceed my indebtedness to the clinic for those services). I understand that I am financially responsible for charges not covered by my insurance.

Please be aware that we require 72 hours from the time of initial notification to call in refills of medicines to your pharmacy.

An administration charge of $35.00 will be applicable for all letters and forms needed to be completed by the physician. This payment must be made at initial request or drop-off of paperwork.

We ask your permission to obtain formulary information and information about other prescriptions prescribed by other providers using RxHub. Consent would allow us to:

1) Determine the pharmacy benefits and drug copays for a patient's participating health plan.
2) Check whether a prescribed medication is covered (in formulary) under a patient's health plan.
3) Display therapeutic alternatives with preference rank within a drug class for non-formulary medications.
4) Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies.
5) Download a historic list of all medications prescribed for a patient by any provider.

_____

Patient or legally authorized individual signature Date

ROS ADULT FEMALE

Constitutional
Y N chills
Y N tiredness
Y N fever
Y N night sweats
Y N weight gain
Y N weight loss

Eyes
Y N blurred vision
Y N glasses/contacts

Ears/Nose/Throat
Y N ear pain
Y N nasal congestion
Y N runny nose
Y N hoarseness
Y N sore throat
Y N tooth pain

Cardiovascular
Y N chest pain
Y N dizziness
Y N irregular heart beat
Y N rapid heart beat

Respiratory
Y N cough
Y N shortness of breath

Musculoskeletal
Y N joint pain
Y N back pain
Y N joint stiffness
Y N muscle pain

Gastrointestinal
Y N abdominal pain
Y N acid reflux
Y N anorexia
Y N bloating

Gastrointestinal
Y N trouble swallowing
Y N constipation
Y N diarrhea
Y N heartburn
Y N hemorrhoids
Y N dark/tarry stool
Y N nausea
Y N vomiting

Genitourinary
Y N painful periods
Y N painful intercourse
Y N painful urination
Y N genital lesions
Y N blood in urine
Y N hi risk sexual pattern
Y N irregular menstrual
Y N heavy periods
Y N waking at night to urinate
Y N excessive urination
Y N bleeding after intercourse
Y N menopausal bleeding
Y N history of rape
Y N sexual abuse
Y N urinary incontinence
Y N vaginal discharge
Y N vaginal itching

Skin/Breast
Y N acne
Y N atypical mole/s
Y N dry skin
Y N yellow tinted skin
Y N itching
Y N rash
Y N wart/s
Y N breast mass
Y N breast skin changes
Y N breast tenderness
Y N nipple discharge
Y N self breast exams ?

Neurological
Y N dizziness
Y N fainting
Y N headaches

Hematologic/Lymphatic
Y N easy bruising
Y N excessive bleeding
Y N past blood transfusion
Y N enlarge lymph nodes

Endocrine
Y N hair loss
Y N heat/cold intolerance
Y N hot flashes
Y N infertility
Y N excessive thirst
Y N excessive hunger

Allergic/Immunologic
Y N seasonal allergies
Y N HIV risk factors

Psychiatric
Y N anxiety
Y N crying spells
Y N depression
Y N stressed
Y N no interest in activities
Y N mood swings
Y N personality change
Y N PMS
Y N poor concentration
Y N recreational drug use
Y N sadness
Y N trouble sleeping
Y N suicidal thoughts

Guadalupe Urology
Dr. Robert T. Ryan, III

Patient Consent for Physician to Use or Disclose Health Care Information for Treatment, Payment and Health Care Operations

Patient's Name:_____ DOB:_____

I understand that my health information is private and confidential. I understand that Dr. Robert Ryan, III works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means Dr. Robert Ryan, III may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to treat me.

Dr. Robert Ryan, III has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Dr. Robert Ryan, III may update this "Notice of Privacy Practices". If I ask, Dr. Robert Ryan, III will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Dr. Robert Ryan, III to restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Dr. Robert Ryan, III does not have to agree to my request. If Dr. Robert Ryan, III does agree to my request, I understand that Dr. Robert Ryan, III would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel the consent, I understand that Dr. Robert Ryan, III may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed.

I may cancel this consent at any time by doing one of the following:

1) Signing and dating a form that Dr. Robert Ryan, III can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or
2) Writing, signing, and dating a letter to Dr. Robert Ryan, III. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

I understand if I cancel this consent Dr. Robert Ryan, III does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of Dr. Robert Ryan, III's "Notice of Privacy Practices".

_____ _____

Patient or legally authorized individual signature Date

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

****

Please list any individual who you will allow to make inquiries about your health information:

_____ _____

_____ _____

Financial & Office Policy

Thank you for choosing Guadalupe Urology and Dr. Robert Ryan as your provider of urological services. We are committed to providing you with quality and affordable health care. The following outlines our financial and office policies. Please read it, and feel free to ask us any questions.

1. Insurance. We participate in many insurance plans, including Medicare. If you are not insured by a plan we do business with or do not have insurance, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Understanding your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Late appointments. Please call if you are going to be late for your appointment. If you are more than 15 minutes late we may have to reschedule.

10. Minors. A minor must be accompanied by a guarantor for his or her account (the parent or guardian of the minor or other adult accompanying the minor during each visit). An unaccompanied minor will be denied non-emergency treatment unless charges have been pre-authorized to an approved credit plan or insurance plan.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding these policies. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines:

_____

Signature Date