ATLANTA COSMETIC UROLOGY

Tariq S. Hakky M.D.
371 E. Paces Ferry Road N.E.
Suite 550
Atlanta, GA 30305
Phone: 404-400-3120 Fax: 404-481-2454
Email: info@atlantacosmeticurology.com

Patient Information

Name:_____

Street Address:

_____

_____

City:_____

Zip code: _____

Phone:(_____)_____

Email Address: _____

Date of Birth: _____

Social Security: _____

Race:_____

Preferred Language: _____

Employer Name: _____

Employer Phone:(_____)_____

Employer Address: _____

Emergency Contact Information

Name:_____

Phone Number: (_____)_____

Relationship To Patient: _____

Alternate Phone Number:(____)_____

Physician Information

(Please list other doctors with whom you wish us to send communication)

Primary Care Physician:

_____

Phone:

(_____)_____

Address:

_____

Referring Doctor:

_____

Phone :

(_____)_____

Address:

_____

Pharmacy

Pharmacy Name:_____

Pharmacy Number:(_____)_____

Pharmacy Address:

_____

To the best of my knowledge, all of this is true and complete. I understand that I am responsible to pay for all services rendered to me, I grant permission to my physician to mutually exchange medical information with referring physician and/or associates. I hereby authorize disclosure of my medical records to my insurance carrier to obtain reimbursement.

Patient Signature:_____ Date: _____

Scan me

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History of Present Illness

Name: _____

Doctor that referred you to Atlanta Cosmetic Urology:

_____

Do you have a cardiologist? ☐**Yes or** ☐**No**

If yes, please list their name: _____

Cardiologist Phone: (___)_____

What is the reason for your visit today?

_____

Do you have any medication allergies / reaction:

_____

_____

_____

Other Allergies: _____

Do you take any medications? ☐**Yes or** ☐**No**

Please list all medication(s) including dosages both prescription and over-the-counter:

_____

_____

_____

_____

Please list all significant medical history:

_____

_____

_____

_____

Please list all prior surgeries and year performed:

_____

_____

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Name: _____

Do you take prescription blood thinners? ☐**Yes or** ☐**No**

Do you take aspirin or anti-inflammatory medicines every day? ☐**Yes or** ☐**No**

Have you had a joint replacement? ☐**Yes or** ☐**No**

Are you allergic to latex? ☐**Yes or** ☐**No**

Are you allergic to intravenous contrast (IV dye)? ☐**Yes or** ☐**No**

WOMEN

Number of Pregnancies:_____

Number of children born: _____

Are you currently pregnant? ☐**Yes or** ☐**No**

Social History

Marital Status: _____
Occupation:_____
Do you use tobacco products: ☐**Yes or** ☐**No**
How many packs per day? _____
How many years:_____
Have you tried to quit?_____

Do you have an Advance Directive: ☐**Yes/**☐**No**
Do you drink alcohol: ☐**Yes or** ☐**No**
How often?
Daily Weekly Monthly Socially Rarely

Family History

Do any one of your family members have any of the following:

- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ BPH (Prostate Enlargement)
- ☐ Inflammatory Bowel Disease
- ☐ Kidney stones
- ☐ Seizure Disorder
- ☐ Kidney Failure
- ☐ Thyroid Disorder
- ☐ Urinary Tract Stones
- ☐ Migraines
- ☐ Cerebrovascular (Stroke)
- ☐ Eczema
- ☐ Cancer _____
- ☐ Diabetes
- ☐ Coronary Artery Disease
- ☐ Prostate Cancer
- ☐ Bladder Cancer
- ☐ Testicle cancer

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Name: _____

Review of Systems:

Constitutional
Changes in appetite ☐Yes or ☐No
Chills ☐Yes or ☐No
Fatigue ☐Yes or ☐No
Fever ☐Yes or ☐No

Eyes
Blurred Vision ☐Yes or ☐No
Changes in Vision ☐Yes or ☐No
☐Yes or ☐No

Genital
Impotence ☐Yes or ☐No
Rapid ejaculation ☐Yes or ☐No
Scrotal Pain ☐Yes or ☐No
Vaginal pain ☐Yes or ☐No
Pelvic pain ☐Yes or ☐No

Neurological
Headaches ☐Yes or ☐No
Numbness or tingling ☐Yes or ☐No
Seizures ☐Yes or ☐No
Lack of coordination ☐Yes or ☐No

Chest/Breast
Lumps ☐Yes or ☐No
Nipple discharge ☐Yes or ☐No
Tenderness ☐Yes or ☐No
Swelling ☐Yes or ☐No

Cardiovascular
Heart Murmurs ☐Yes or ☐No

Urinary
Decreased urinary stream ☐Yes or ☐No
Painful urination ☐Yes or ☐No
Frequency of urination ☐Yes or ☐No
Incontinence ☐Yes or ☐No
Urgency ☐Yes or ☐No
Frequent urination at night ☐Yes or ☐No
Post-void dribbling ☐Yes or ☐No

Ears, Nose, & Throat
Headaches ☐Yes or ☐No
Nasal Congestion ☐Yes or ☐No
Sinus pain ☐Yes or ☐No

Allergic/Skin
Dermatitis ☐Yes or ☐No
Skin rash ☐Yes or ☐No
Chest pain ☐Yes or ☐No
Irregular heart beat ☐Yes or ☐No

Respiratory
Wheezing ☐Yes or ☐No
Shortness of Breath ☐Yes or ☐No
Cough ☐Yes or ☐No

Gastrointestinal
Nausea ☐Yes or ☐No
Vomiting ☐Yes or ☐No
Diarrhea ☐Yes or ☐No
Abdominal pain ☐Yes or ☐No
Bloody stools ☐Yes or ☐No
Black stools ☐Yes or ☐No

Endocrine
Cold intolerance ☐Yes or ☐No
Excessive thirst ☐Yes or ☐No
Heat intolerance ☐Yes or ☐No
Weight gain ☐Yes or ☐No
Weight loss ☐Yes or ☐No

Musculoskeletal
Back pain ☐Yes or ☐No
Bone pain ☐Yes or ☐No
Joint pain ☐Yes or ☐No
Muscle pain ☐Yes or ☐No

Hematologic
Easy bruising ☐Yes or ☐No
Deep vein thrombosis (Clots) ☐Yes or ☐No
Easy bleeding ☐Yes or ☐No

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Authorization To Release Medical Information

Patient Name:_____

Date of Birth: _____

I authorize Atlanta Cosmetic Urology to release my medical information to another person(s)/family member(s).

(This is separate from Emergency Contact)

☐ **Yes or** ☐ **No**

Name:_____ Relationship: _____

Phone Number:(____)_____

☐ **Yes or** ☐ **No**

Name: _____ Relationship: _____

Phone Number:(____)_____

☐ **Yes or** ☐ **No**

Name: _____ Relationship: _____

Phone Number:(____)_____

Patient Signature:_____ Date: _____

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Authorization for the Release of Protected Health Information (PHI)

Patient Name: _____

Date of Birth: _____

Phone Number: (_____)_____

I authorize the staff from Atlanta Cosmetic Urology to release or obtain the health information as directed below:

Patient to obtain from and or release to:

Facility: _____

Address: _____

Phone Number: (_____)_____

Fax Number: (_____)_____

Release to/Obtain from:

Atlanta Cosmetic Urology
371 E. Paces Ferry Road NE
Suite 550
Atlanta GA 30305
Phone:(404) 400-3120 Fax:(404) 481-2454

This request applies to:

Healthcare information relating to the following treatment, condition, or dates.

Patient Signature:_____Date: _____

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Payment Policy

Thank you for choosing Atlanta Cosmetic Urology as your Urology provider. We are committed to providing you with premiere Urological care.

Insurance:

We participate in several insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

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. If unfortunately we send your account to a Collection Agency, a $200 collections processing fee will be added to any outstanding balance.

Non-covered services:

Please be aware that some 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.

Proof of insurance:

All patients must complete our patient information form before seeing the doctor. We must obtain an up to date copy of your driver's license that is valid. We also need a copy of your valid up to date insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Insurance 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. You will be responsible if there are any issues or lapses in care.

Nonpayment:

If your account is over 90 days past due, you will receive a letter stating that you

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have 20 days to pay your account. If your balance remains unpaid, we will refer your account to a collection agency.

Missed procedures and IV infusions:

Our policy is to charge for missed procedures and IV infusions if they are not canceled within a reasonable amount of time (<24hrs). You will be responsible for the $250.00 and this will be your responsibility and billed directly to you.

I have read and understand the payment policy and agree to abide by its guidelines.

Patient Signature:_____ Date: _____