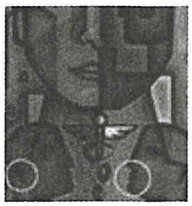

ENTRUST
MEDICAL GROUP

PATIENT REGISTRATION INFORMATION

(Please PRINT and complete all sections below)

PATIENT'S PERSONAL INFORMATION

Name: _____ Sex: M ❑ F ❑ Age: _____ Date of Birth: _____
First MI Last

Address: _____ City _____ State _____ Zip _____

Social Security # _____ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Preferred Method of Contact:

Home Phone (_____) _____ Approval to leave message? ❑ Y ❑ N

Cell Phone (_____) _____ Approval to leave message? ❑ Y ❑ N

Email Address _____ Approval to leave message? ❑ Y ❑ N

**Can we reach you by email for appointment reminders / reschedule? ❑ Yes ❑ No

Work Phone: (_____) _____ Approval to leave message? ❑ Y ❑ N

Employer: _____ Occupation: _____

Work Address: _____ City _____ State _____ Zip _____

PRIMARY CARE PHYSICIAN: _____ Phone (_____) _____

Which physician referred you to us? _____ Other: _____

EMERGENCY CONTACT: _____ Phone (_____) _____
Name and Relationship

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Name of Financially Responsible Person: _____

Address: _____ City _____ State _____ Zip _____

Relationship to Patient: _____ Social Security # _____ Date of Birth: _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Employer: _____ Occupation: _____

SPOUSE NAME: _____ Date of Birth: _____

Spouse Employer: _____ Spouse Occupation: _____

**Preferred method of contact: ❑ Cell ❑ Home ❑ Work Approval to leave message or email? ❑ Y ❑ N

PATIENT'S INSURANCE INFORMATION AND ELIGIBILITY GUARANTEE

PRIMARY INSURANCE COMPANY

Insurance Company Name: _____ Name of Insured Person: _____

Insured Date of Birth: _____ Insured Social Security # _____

SECONDARY INSURANCE COMPANY

Insurance Company Name: _____ Name of Insured Person: _____

Insured Date of Birth: _____ Insured Social Security # _____

I, THE UNDERSIGNED, REALIZE THAT ALL MEDICAL AND SURGICAL CHARGES INCURRED ARE MY FINANCIAL RESPONSIBILITY AND PAYABLE BY ME. I UNDERSTAND THE OFFICE WILL DO ITS BEST TO BILL ANY INSURANCE THAT I MAY HAVE, BUT I AM STILL ULTIMATELY RESPONSIBLE FOR THE CHARGES. I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER TO PAY DIRECTLY TO ENTRUST MEDICAL GROUP ANY BENEFITS DUE TO ME AND UNDER MY INSURANCE PLAN, INCLUDING DEDUCTIBLES AND CO-PAYMENTS. I AUTHORIZE RELEASE OF INFORMATION FROM MY MEDICAL RECORD REQUIRED FOR TREATMENT OR BILLING PURPOSES.

_____ _____
AUTHORIZED SIGNATURE DATE

ENTRUST
MEDICAL GROUP

Acknowledgement of Receipt of Notice of Privacy Practices

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices***. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. I acknowledge receipt of the ***Notice of Privacy Practices***.

Signature:		Date:
Print Name:		Date:

If not signed by the patient, please indicate who signed:

□ Parent or guardian of minor patient
□ Guardian or conservator of an incompetent patient
□ Beneficiary or personal representative of deceased patient

Name of Patient:_____

Confidential Contact Information

- If it becomes necessary to contact you by phone, do we have your permission to leave messages on your answering machine or voicemail? □ Yes or □ No
- What is the best time of day to reach you? _____
- Where do you prefer to receive our call? □ Home phone/ □ Work phone/ □ Cell phone

Disclosure of Confidential Health Information

I agree that ENTRUST Medical group, may disclose/discuss my health information with the following persons listed below as persons involved with my healthcare. I understand that I am not required to list anyone. I also understand that I may change this list at any time.

Name/Relationship _____ Phone_____

Name/Relationship _____ Phone_____

Name/Relationship _____ Phone_____

For office use only: Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: Date:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please Specify) _____

Entrust Medical Group
Urology and Urologic Surgery
William F. Pearce, M.D.
Hari Sawkar, M.D.

Patient Name: _____

Date of Birth: _____

Primary Care Provider: _____

Patient Summary Form

Preferred Pharmacy Name & Phone # _____ Drug Allergies/Sensitivities: _____

REASON FOR THIS APPOINTMENT

Chronic Medical Problem List	Date	Past Surgical History	Date
		Hospitalizations	**Date**
Medications			

Family History of

Y	N		Family Member
☐	☐	Alzheimer's Dz	_____
☐	☐	Breast Ca	_____
☐	☐	CAD	_____
☐	☐	Cerebrovas, Dz	_____
☐	☐	Cervical Cancer	_____
☐	☐	Colon CA	_____
☐	☐	Depression	_____
☐	☐	DM	_____
☐	☐	Fe Storage	_____
☐	☐	Glaucoma	_____
☐	☐	Hyperchol.	_____
☐	☐	HTN	_____
☐	☐	Ovarian CA	_____
☐	☐	Prostate CA	_____
☐	☐	Skin CA	_____
☐	☐	Thyroid Dz	_____

Social History

☐ Married ☐ Single ☐ Separated

☐ Divorced ☐ Widow(er)

Number of Children _____ (M/F)

Occupation: _____

Religious Preference: _____

Advance Directive? ☐ Yes ☐ No

If Yes, Date: _____

Educ.: ☐ JHS ☐ HS ☐ College

☐ Other _____

Signature: _____ Date: _____

POS Reorder # 1901126

William F. Pearce, M.D.
Hari Sawkar, M.D.

PATIENT REVIEW OF SYSTEMS - DETAILED HEALTH HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS BY **CIRCLING** YES OR NO.
IF NOT SURE, PLEASE ANSWER AS BEST AS YOU CAN.

GENERAL

Have you had any recent weight gain?	YES	NO
Have you had any recent weight loss?	YES	NO
Do you use tobacco in any form?	YES	NO
Do you use alcohol in any form?	YES	NO
Have you used drugs like marijuana, cocaine, or amphetamines?	YES	NO

GENITOURINARY

Do you wet yourself?	YES	NO
Have you ever had an infection in your urine?	YES	NO
Have you ever had a sexually transmitted disease?	YES	NO
Have you ever had kidney pain?	YES	NO
Have you ever had a kidney stone?	YES	NO
Do you get up every night to urinate?	YES	NO
Do you have to strain to empty your bladder?	YES	NO
Have you ever had cancer in your urinary tract?	YES	NO
Do you have trouble when you try to have sex?	YES	NO

HEAD AND NERVES

Do you have trouble with headaches?	YES	NO
Do you have trouble seeing?	YES	NO
Do you have trouble hearing?	YES	NO
Has your voice changed during the last year?	YES	NO
Do you have trouble with nosebleeds?	YES	NO
Do you have seizures/convulsions?	YES	NO
Do you have blackout spells?	YES	NO
Have you ever had a stroke?	YES	NO
Have you ever been paralyzed?	YES	NO
Have you ever been treated for mental illness?	YES	NO

LUNGS

Do you have asthma, emphysema, chronic bronchitis, or COPD?	YES	NO
Do you have a cough every day?	YES	NO
Have you ever coughed up blood?	YES	NO
Do you have shortness of breath?	YES	NO
Have you ever had pneumonia?	YES	NO

HEART AND BLOOD VESSELS

Have you ever had a heart attack?	YES	NO
Do you have pains in your chest?	YES	NO
Is your heartbeat irregular?	YES	NO
Do you get pain in your lower legs when you walk?	YES	NO

GASTROINTESTINAL

Do you vomit frequently?	YES	NO
Have you ever vomited blood?	YES	NO
Have you had ulcers?	YES	NO
Have you ever passed blood with your bowel movements?	YES	NO
Do you usually have bowel trouble?	YES	NO

OTHER

Have you ever had a blood transfusion?	YES	NO
Is there anything else you want to tell us?	YES	NO

May we send records to your family doctor?
If so, please list doctor's name: _____

YOUR NAME: _____

YOUR SIGNATURE: _____

TODAY'S DATE: _____/_____/_____ M.D. SIGNATURE: _____