THOMAS UROLOGY CLINIC
PATIENT REGISTRATION

Patient Name: (Last)_____(First) _____ Middle Initial_____

Address: _____ City, State, Zip: _____

Marital Status: Single Married Widowed Divorced

DOB: _____/_____/_____ SSN: _____ ☐ Male ☐ Female

Primary Phone: _____ Alt Phone:_____

Email(Used for invitation to Patient Portal & notification of appointments): _____

Primary Doctor: _____ Referring Doctor: _____

RESPONSIBLE PARTY(If patient is not responsible for bill payment, please indicate who is responsible)

Name: (Last) _____ (First) _____ (MI) _____ DOB: _____

Phone: (__)_____ Address: _____

City, State, Zip: _____ Relationship to Patient: _____

PRIMARY INSURANCE: _____ ID: _____

Policy Holder Name: (Last) _____ (First) _____ (MI) _____

DOB: _____ Relationship to Patient _____

SECONDARY INSURANCE _____ ID: _____

Policy Holder Name: (Last) _____ (First) _____ (MI) _____

DOB: _____ Relationship to Patient _____

EMERGENCY CONTACT

Name: (Last) _____ (First) _____

Phone: _____Relationship to Patient: _____

PREFERRED PHARMACY: _____Address: _____

AUTHORIZATION FOR PERSONS TO WHOM MY MEDICAL INFORMATION MAY BE DISCLOSED:

_____	_____	_____
Person's Name/Organization	Relationship to Patient	Contact info
_____	_____	_____
Person's Name/Organization	Relationship to Patient	Contact info

Patient signature:_____ **Date:**_____

THOMAS UROLOGY CLINIC

KENNETH R. THOMAS, MD
MICHELLE BEASLEY, FNP-C
109 DOCTORS PARK
STARKVILLE, MS 39759
PHONE: 662.498.1400
FAX: 662.498.1407

CONSENT TO TREAT

I hereby authorize Kenneth Thomas, MD to administer treatment and medications as may be deemed medically necessary and advisable.

AUTHORIZE TO RELEASE INFORMATION & ASSIGNEMENT OF BENEFITS

I hereby authorize Kenneth Thomas, MD or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare), Insurance companies or third parties, any information needed to determine these benefits payable for the related services.

I request that authorized Medicare or Insurance payments of medical benefits be made to Kenneth Thomas, MD.

FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Kenneth Thomas, MD, Thomas Urology Clinic and if this assignment is rejected, modified or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. I also understand and agree that all deductibles, coinsurance, non-covered charges and other items not paid by insurance, health plan or other third party payers are due and payable at time of service. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel and court.

This authorization and assignment may be revoked by me at any time by written notice.
I agree that a photocopy of this form may be used in lieu of the original.

CLINIC PROVIDER POLICY

Thomas Urology Clinic has multiple providers on staff, including Nurse Practitioners. Due to patient volume, we cannot guarantee that you will be seen by any particular provider. Our providers collaborate to give you the best possible care. By signing below, you acknowledge this clinic policy.

RECIEPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received a copy of Thomas Urology Clinic's Notice of Privacy Practices.

_____
Patient Signature

_____ _____
Patient Name (printed) Date

VASECTOMY HISTORY FORM

Name: _____

Date of Birth: _____

Are you married? _____

How many children do you have? _____

If married, what is your wife's age? _____

How long have you been married? _____

Have you ever had any of the following? (PLEASE CHECK ALL THAT APPLY.)

- o scrotal surgery
- o erectile dysfunction
- o epididymitis
- o orchitis
- o prostatitis
- o scrotal pain

Allergies: _____

_____

Medications: _____

_____

Medical/ Surgical History: _____

_____

Do you have any history of a bleeding disorder? _____