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

Patient signature:________________________ **Date:**________________

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

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PEDIATRIC MEDICAL HISTORY FORM

NAME: ____

AGE: __________ DOB: __________

DATE: ________ PHONE: ________________ PEDIATRICIAN: _____________

HEIGHT: ________WEIGHT: ________

Why is your child being seen? ____

____

PRENATAL DEVELOPMENT:
(CHECK ALL THAT APPLY AND EXPLAIN COMPLICATIONS AND/OR REASONS FOR C SECTION.)

PREGNANCY:
◯ - NO COMPLICATIONS ◯- COMPLICATIONS: ________________________

DELIVERY:
GESTATIONAL AGE: ________ ◯- VAGINAL ◯ - C SECTION ________________

CHILDS PAST MEDICAL HISTORY: (PLEASE, CIRCLE ALL THAT APPLY.)

LUNG PROBLEMS	HEART PROBLEMS	DIARRHEA	SOCIAL PROBLEMS
HIGH BLOOD PRESSURE	DEVELOPMENTAL CONCERNS	CANCER	CONSTIPATION
KIDNEY DISEASE	ANEMIA	DIABETES	IMMUNIZATION

OPERATIONS: (PLEASE, CIRCLE ALL THAT APPLY.)

CIRCUMCISION	TESTICLE SURGERY	HERNIA	BLADDER SURGERY
TONSILS	KIDNEY SURGERY	APPENDIX	HEART SURGERY

HOSPITALIZATIONS:(LIST ALL PREVIOUS HOSPITALIZATIONS AND DATES OF TREATMENT.)

____
____
____
____

MEDICATIONS: (PLEASE INCLUDE DOSAGE AND TIMES.)________________________

____

MEDICATION ALLERGIES: ______________________

FAMILY HISTORY:
PLEASE LIST ANY DISEASE THAT RUNS IN YOUR FAMILY SUCH AS CANCER, KIDNEY STONES, DIABETES, ECT.

DISEASE	FAMILY MEMBER

REVIEW OF SYSTEMS: (PLEASE CHECK ALL ROWS)

	YES	NO
1. CONSTITUTIONAL SYMPTOMS		
FEVER		
CHILLS		
HEADACHES		
2. EYES		
POOR VISION		
3. HEAD & NECK		
HEARING LOSS		
SORE THROAT		
4. CARDIO VASCULAR		
HIGH BLOOD PRESSURE		
HEART MURMUR		
5. RESPIRATORY		
COUGH		
ASTHMA		
6. GASTROINTESTINAL		
CONSTIPATION		
DIARRHEA		
7. MUSCULOSKELETAL		
BROKEN BONE		

	YES	NO
8. HEMATOLOGIC		
EASY BRUISING		
BLEEDING DISORDER		
9. ALLERGIC		
ALLERGIES		
HAYFEVER		
10. NEUROLOGIC		
SEIZURES		
MUSCLE WEAKNESS		
11. GENITAL		
HERNIA		
TESTICLE PROBLEMS		
HYPOSPADIAS		
12. DEVELOPMENT		
ADHD		
DEPRESSION		
ANXIETY		

13. AGE POTTY TRAINED ______________

14. AGE MENSES BEGAN ______________

SOCIAL:

GRADE IN SCHOOL: __________

LIVING WITH:

MOM	
DAD	
BOTH	

	YES	NO
CIGARETTE USE		
ALCOHOL USE		

I HAVE REVIEWED THE CONTENTS OF THE HISTORY IN ITS ENTIRETY.

M.D. Signature:______________________________ Date: ______________