Central Indiana Urology, PC
8902 N Meridian St. Ste 135
Indianapolis, IN 46260
Dr. Steven Kim

Welcome to Central Indiana Urology, PC,

It is our goal to make your visit with us a smooth and comfortable one. We have been, and continue to be, committed to the highest of ethical standards in the conduct of our healthcare and business operations.

We demand of ourselves full compliance with all federal state and local laws. We are committed to preventing, detecting and disciplining any unethical behavior.

We ask that you complete each form in the attached packet, making sure every line is filled in. This will make our job in assisting you that much more efficient. Please also take the time to read each form carefully so that you are familiar with our policy.

If you have insurance, please bring your insurance card(s) with you. Also, we ask that you bring a photo ID as well. Present all information to the receptionist upon arrival to the office.

It is your responsibility to know your insurance benefits. If your insurance requires that you have a referral or you are bringing records from your physician, you must bring these with you to your appointment or you will be rescheduled. If you make arrangements to have these faxed, please call at least two days prior to your appointment to make sure they have arrived. If they have not arrived, we will let you know so that you can call for them as this is the responsibility of the patient. Please do not rely on your primary care physician's office to do this for you.

Please be aware that we are not contracted with some insurance companies (even though we may be listed on their internet site and a customer service representative may state that we do). Please check your card and call your insurance company to verify. When calling your insurance company, give our address listed above and ask for the tax ID number being billed. Then call our office so we can confirm that it is the correct tax ID number.

If you have any questions regarding any of the forms in your packet, please do not hesitate to contact our office.

We appreciate your choice of Central Indiana Urology, PC for your healthcare needs.

Sincerely,

Dr. Kim and Staff
Central Indiana Urology, PC

Central Indiana Urology, PC
Dr. Steven Kim

PATIENT REGISTRATION FORM

General Information

Last Name:_____First:_____ M.I._____

Address: _____

City:_____State:_____Zip:_____

Home#_____Work#_____ Cell#_____

Date of Birth: _____ Sex: Male_____Female _____ Email:_____

Employer:_____

Marital Status: ____Single ____ Married ____Separated _____Divorced _____Widowed

Spouse/Partner Name:_____

Ethnicity (circle one) 1) Non-Hispanic 2) Hispanic 3) Refused to report

Primary Race (circle one) 1) White 2) Hispanic 3) Black or African American 4) Asian 5) American Indian 6) Native Hawaiian 7) Other Race 8) Unreported

Language (circle one) 1) English 2) Spanish 3) Other

May we leave a person message on your answering machine regarding your medical condition?

_____Yes _____No

Do we have permission to talk to another person (spouse, family member) about our medical condition or account information? _____Yes _____No

If yes, name of person (s):_____ Relation to you:_____

Referring Physician:_____ Phone#_____

Primary Care Physician:_____ Phone#_____

Emergency Contact:_____ Phone#_____

Relationship of Emergency Contact:_____

PRIMARY INSURANCE

_____

ID Number:_____

Member:_____

Member DOB:_____

Employer:_____

SECONDARY INSURANCE

_____

ID Number:_____

Member:_____

Member DOB:_____

Employer:_____

Pharmacy :_____Address:_____Phone:_____

Patient/Guardian Authorization to disclose Protected Health Information to Others

Patient Name:_____ DOB:_____ Today Date:_____

To the patient: Central Indiana Urology, PC will attempt to follow your instructions to the extent the healthcare provider believes such disclosure will not interfere with your treatment. Please note that Central Indiana Urology, PC does not need specific authorization to disclose information for treatment, operations or payment purposes consistent with its Notice of Privacy Practices.

Authorization by: _____Patient _____Legal Guardian: _____

Central Indiana Urology, PC may disclose all of my Protected Health Information* (including that about alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or information related to psychiatric treatment or counseling, and related to communicable disease, unless I limit below) to:

_____ Spouse (name) _____

_____Child(ren): All _____ or by name _____

_____

_____Others (name): _____

***Limitation** – The following Protected Health Information may NOT be disclosed:

_____

_____

_____

***Expiration** – I understand this Authorization will stay in effect during my treatment at Central Indiana Urology, PC unless it is revoked/revised by me **in writing**. I understand that Central Indiana Urology, PC is not responsible for information that might be re0disclosed by those persons who I have authorized to receive information.

Patient/Guardian Signature:_____

Date:_____

Name:_____

DOB:_____

Date:_____

Email:_____

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8902 N Meridian St Ste 135
Indianapolis, IN 46260-3890

PATIENT HISTORY FORM

Referring
Physican:_____

Height: _____ Weight:_____ Pulse:_____

Chief Complaint_____

_____

History of Present Illness_____

_____

_____

PAST MEDICAL AND SOCIAL HISTORY
Patients start answering questions HERE:

Please list any past illnesses_____

_____

_____

Please list any prior surgeries

_____

_____

Please list any medications (including aspirin and/or frequent over the counter)_____

_____

_____

Please list any allergies_____

_____

_____

_____

SOCIAL HISTORY

Do you smoke? YES or NO
If yes, how much?

_____

Do you drink alcohol? YES or NO
If yes, how much?

_____

Do you drink caffeine? YES or NO
If yes, how much?

_____

Are you married or in a steady relationship? YES or NO

_____

Do you follow a special diet? YES or NO
If yes, please explain?

_____

_____

FAMILY HISTORY

Do you have a family history of cancer (kidney, bladder, prostate, testicles)? Yes or NO
If yes, please explain_____

_____

_____

Do you have a family history of Kidney Stones or blood in the urine? Yes or NO
If yes, please explain_____

_____

_____

Do you have a family history of tuberculosis, diabetes or heart disease? YES or NO
If yes, please explain_____

_____

_____

REVIEW OF SYSTEMS

Do you have problems with the following:

Constitutional Systems			**Integument**		
Fever	Y	N	Skin rash	Y	N
Chills	Y	N	Persistent itch	Y	N
Headaches	Y	N			
Eyes			**Musculoskeletal**		
Blurred Vision	Y	N	Joint Pain	Y	N
Double Vision	Y	N	Neck Pain	Y	N
			Back Pain	Y	N
Allergy/Immunologic			**Genitourinary**		
Hay Fever	Y	N	Painful urination	Y	N
Drug Allergies	Y	N	Blood in urine	Y	N
			(Men) Erectile Dysfunction	Y	N
			(Women) Painful Intercourse	Y	N
			(Women) Abnormal periods	Y	N
Neurological			**Respiratory**		
Tremors	Y	N	Shortness of Breath	Y	N
Seizures	Y	N	Frequent Cough	Y	N
Stroke	Y	N			
Endocrine			**Hematologic/Lymphatic**		
Excessive thirst	Y	N	Swollen glands	Y	N
Excessive fatigue	Y	N	Bleeding problems	Y	N
Loss of Libido (sexual interest)	Y	N			
Cardiovascular			**Psychological**		
Chest pain	Y	N	Feeling severely depressed	Y	N
Palpitations	Y	N	Do you feel satisfied with your life	Y	N
High blood pressure	Y	N			