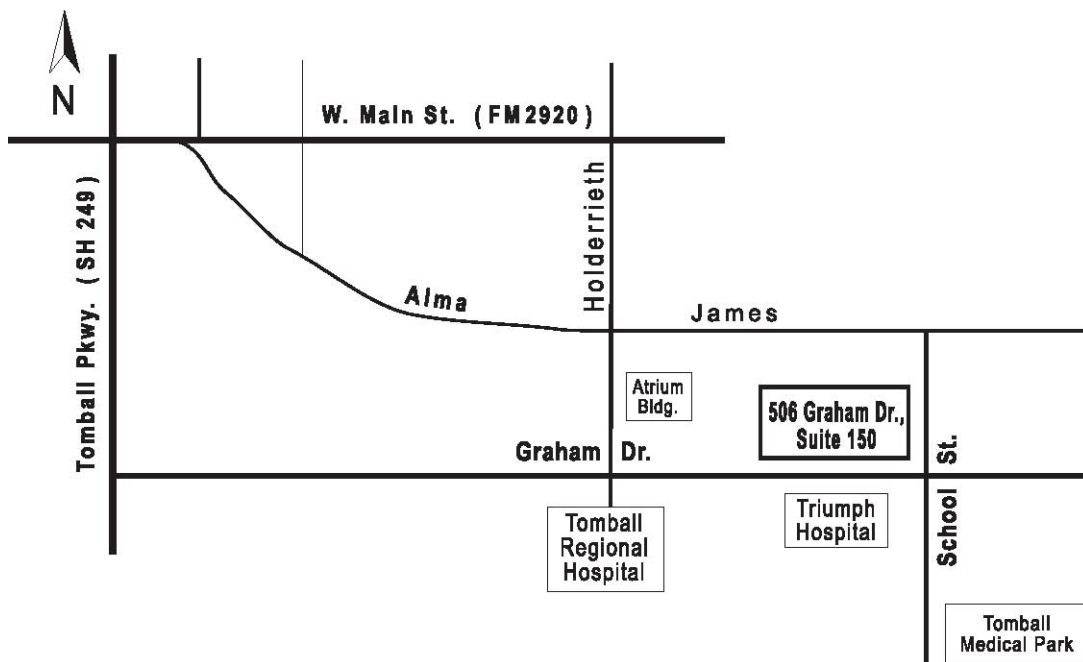




Urology Specialists, P.A.

**Steven W. Sukin, M.D.**  
Diplomate, American Board of Urology  
**Patrick J. Zielie, M.D.**  
Diplomat, American Board of Urology



-Most Insurance & Major Credit Cards Accepted-

**281-351-5174**

506 Graham Drive, Suite 150 \* Tomball, Texas 77375

[www.DrStevenSukinUrology.com](http://www.DrStevenSukinUrology.com)



506 GRAHAM DRIVE, SUITE 150  
TOMBALL, TEXAS 77375  
PHONE: 281-351-5174 FAX: 281-351-5172

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**I hereby authorize the use or disclosure of information from the medical record of:**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ (optional)

I authorize the following individual or organization to disclose the above named individual's health information

Address \_\_\_\_\_ Phone \_\_\_\_\_

For the purpose of  Continued Care  Attorney/Legal  Personal use  Insurance  Other

Please release the following:

- \_\_\_ Problem List X-Ray/Imaging Reports from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
  - \_\_\_ Progress Notes X-Ray Films (date) \_\_\_\_\_
  - \_\_\_ History/Physical Exam Laboratory Results from (date) \_\_\_\_\_ to (date) \_\_\_\_\_
  - \_\_\_ Medication List EKG Reports
  - \_\_\_ Immunization Record Genetic Testing Information
  - \_\_\_ List of Allergies Other Diagnostic Reports (Specify) \_\_\_\_\_
- Other (Specify) \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

X \_\_\_\_\_

If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provide in CFG 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact office the manager/privacy officer.

X \_\_\_\_\_  
Signature of Patient or Legal Representative

X \_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient or Legal Representative

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Texas Urology Specialists liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for correct interpretation:

X \_\_\_\_\_  
Signature of Patient or Legal Representative

X \_\_\_\_\_  
Date

X \_\_\_\_\_  
Relationship to Patient (if Legal Representative)

X \_\_\_\_\_  
Witness



Urology Specialists, P.A.

### Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Texas Urology Specialists for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the practice’s health care operations. I understand that diagnosis or treatment of me by Dr. Steven W. Sukin, Dr. Patrick J. Zielie or Dr. Brenda Tharian may be conditioned upon my consent as evidenced by my signature on this document.

***My “protected health information” encompasses health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This is protected health information relates to my past, present or future physical or mental health and identifies me or provides reasonable basis for identifying me.***

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the practices healthcare operations. Urology Specialists is not required to agree to the restrictions that I may request, however if Texas Urology Specialists agrees to a requested restriction, that restrictions binding on both the practice and the attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Texas Urology Specialists has taken action in relevance on this consent.

I understand I have a right to review Texas Urology Specialists ***Notice of Privacy Practices*** prior to signing this document. This Notice of Privacy Practices has been provided to me and is available upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or the performance of health care operations of Urology Specialists. It also describes my rights and Texas Urology Specialists duties with respect to my protected health information.

Texas Urology Specialists reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

**I authorize Texas Urology Specialists to call my home or work to remind me of an appointment or to reschedule an appointment. I also authorize Texas Urology Specialists to leave scheduling information on my answering machine, or voicemail system.**

X \_\_\_\_\_  
Signature of Patient or Personal Representative

X \_\_\_\_\_  
Date

X \_\_\_\_\_  
Printed name of Patient or Personal Representative

X \_\_\_\_\_  
Description of Personal Representative’s Authority

Directions to Urology Specialists of The Woodlands  
ST. Luke's Medical Center  
17198 St. Luke's Way  
Suite 410  
The Woodlands, Texas 77384

From Houston

Travel North on I-45

Take exit 79 toward S.H.242

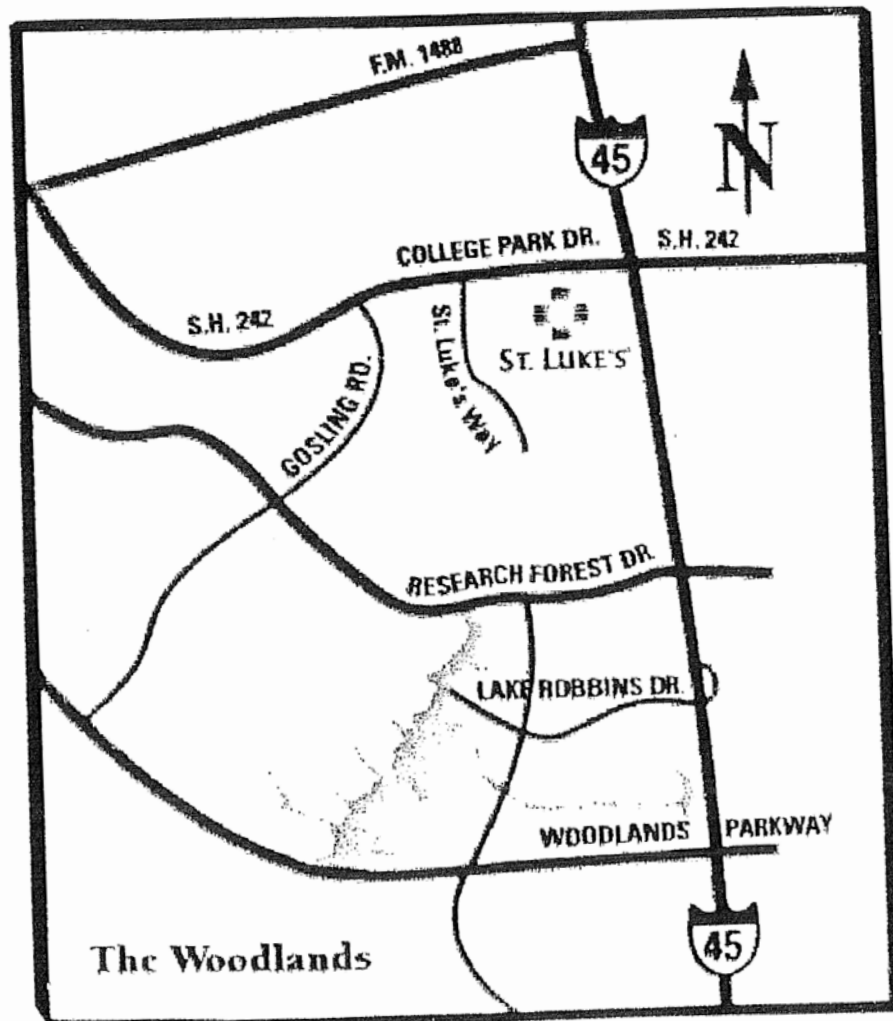
(College Park Drive)

Turn Left on St. Luke's Way

Follow signs to St. Luke's Medical Center

Enter the parking lot

(Dr. Sukin's offices are in the building on the left West entrance, 4<sup>th</sup> floor suite 410)





Urology Specialists, P.A.

(Please Fill Out Completely)

Date: \_\_\_\_\_

Home Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

e-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: M S D W Sex: Male Female

Patient Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Patient Employer \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse Name \_\_\_\_\_ Ok to release Medical Information spouse?  YES  NO

Spouse Employer or School if Child \_\_\_\_\_ Job Title \_\_\_\_\_ Phone \_\_\_\_\_

\*Applies only to parents of minor children or children insured under the parents insurance

\*Parent Name: \_\_\_\_\_ \*Parent Name: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Name / Location \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone: \_\_\_\_\_

Race:  Caucasian  African American  Hispanic  Asian/Indian/Pakastani/Sri Lankan  Chamorran  Chinese  Fiji Islander  Filipino  Guananian NOS  Hawaiian  Hmong  Japanese  Kampuchean/Cambodian  Korean  Laotian  Melanesian NOS  Micronesian NOS  Samoan  Tahitian  Thai  Tongan  Vietnamese  Other \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION

Primary Insurance

Name of Insured: \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Address \_\_\_\_\_

Customer Service Phone Number \_\_\_\_\_

Secondary Insurance

Name of Insured: \_\_\_\_\_

Date of Birth of Insured: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Address \_\_\_\_\_

Customer Service Phone Number \_\_\_\_\_

Signature of Patient

X \_\_\_\_\_

Signature of Responsible Party

X \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**REASON FOR YOUR VISIT TODAY:** \_\_\_\_\_

**Have you or do you have any of the following: Check / Circle all that applies to you**

<input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart attack <input type="checkbox"/> Aneurysm <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Blood Clots in legs <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes Date Diagnosed: _____ <input type="checkbox"/> Hyperthyroidism <b>or</b> Hypothyroidism <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Hepatitis A B Or C <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> Liver disease	<input type="checkbox"/> Urinary Infections <input type="checkbox"/> Prostatitis <input type="checkbox"/> Kidney disease <input type="checkbox"/> Emphysema / Bronchitis <input type="checkbox"/> Lung Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Glaucoma Open or Closed <input type="checkbox"/> Hearing loss <input type="checkbox"/> Depression <input type="checkbox"/> Cancer _____
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**Previous Surgery / Hospitalization (LIST ALL)** \_\_\_\_\_

**Medications:** (INCLUDE OVER THE COUNTER MEDICATIONS AND HERBAL SUPPLEMENTS) \_\_\_\_\_

**DRUG ALLERGIES:** \_\_\_\_\_

**FEMALE PATIENTS ONLY**

Are you or could you be pregnant? Yes / No # of pregnancies: \_\_\_\_\_  
 Date of Last Menstrual Period: \_\_\_\_\_ Type of Birth Control \_\_\_\_\_

**FAMILY HISTORY**

Do any of the following medical problems run in your family?

- |   |  |
|---|--|
| <input type="checkbox"/> Prostate Cancer<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Cancer Type: _____ |
|---|--|



Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL HISTORY**

Exercise: Yes / No Alcohol: Yes / No Amount: \_\_\_\_\_ Caffeine: Amount per day \_\_\_\_\_

Tobacco Usage Yes / No # of Years \_\_\_\_\_, Quit \_\_\_\_\_

Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

**UROLOGICAL HISTORY:**  
(PLEASE CHECK ALL THAT APPLY)

Urological Surgeries / Problems, Please List \_\_\_\_\_  
\_\_\_\_\_

- Any pain or burning when voiding / urinating?
- Any urgency or need to run to the bathroom?
- Any Urinary frequency or need to void many times during the night?
- Any sense of incomplete emptying of your bladder?
- Any leakage of urine?
- Any blood in urine?
- Any pain? If yes, where is your pain located? \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE

(FOR PHYSICIAN USE ONLY)

VITALS: T BP P R WT

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**REVIEW OF SYSTEMS: PLEASE CHECK ALL THAT YOU CURRENTLY HAVE**

**CONSTITUTIONAL**

- FEVER
- CHILLS
- WEIGHT CHANGE

**EYES**

- BLINDNESS
- DOUBLE VISION
- BLURRED VISION
- BURNING
- GLAUCOMA OPEN / CLOSED

**IMMUNOLOGICAL**

- FOOD SENSITIVITY
- ASTHMA
- RECENT VACCINATIONS

**NEUROLOGICAL**

- TREMORS
- DIZZINESS
- HEADACHES
- SEIZURES
- NUMBNESS / TINGLING

**ENDOCRINE**

- HEAT / COLD INTOLERANCE
- INCREASED THIRST
- FREQUENT URINATION
- HAIR LOSS
- TIRED / SLUGGISH

**GASTROINTESTINAL**

- ABDOMINAL PAIN
- DIARRHEA
- NAUSEA / VOMITING
- CONSTIPATION
- INDIGESTION / HEARTBURN
- BLOATING

**CARDIOVASCULAR**

- CHEST PAIN
- PALPITATIONS
- IRREGULAR HEART BEAT
- ANKLE SWELLING
- HEART FAILURE

**MUSCULOSKELETAL**

- MULTIPLE JOINT SWELLING
- GOUT
- MULTIPLE FRACTURE
- NIGHT CRAMPS
- NECK PAIN
- BACK PAIN

**EAR, NOSE, THROAT**

- RINGING IN THE EARS
- HEARING LOSS
- HOARSENESS
- SORE THROAT
- RECURRENT NOSE BLEEDS
- MOUTH ULCERS
- EAR INFECTION

**URINARY**

- PAINFUL URINATION
- URINARY FREQUENCY
- BLOOD IN URINE
- LOSS OF BLADDER CONTROL
- URINARY DISCHARGE

**RESPIRATORY**

- COUGH
- SHORTNESS OF BREATH
- COUGH WITH BLOOD
- WHEEZING

**HEMATOLOGIC**

- SPONTANEOUS BLEEDING
- BRUISING
- ENLARGED LYMPH NODES
- ANEMIA
- JAUNDICE

**PSYCHOLOGICAL**

ARE YOU GENERALLY SATISFIED WITH YOUR LIFE?  
 YES    NO

DO YOU FEEL SEVERLY DEPRESSED?  
 YES    NO

HAVE YOU EVER CONSIDERED SUICIDE?  
 YES    NO