



Piedmont Urology

Dear Patient:

We would like to take this opportunity to thank you for choosing our office for your urologic care and to welcome you to our office. We are pleased that you have chosen us to provide you with your medical services. For your convenience, wireless internet access is available.

Please bring the medications you are currently taking. If you had x-rays made, please bring the films with you when you come to the office.

Enclosed are forms that you need to complete and bring back with you. Please be sure that you bring your current insurance card/s with you so that your claims can be filed properly. If your insurance company requires a referral, please be advised that it is YOUR RESPONSIBILITY TO ENSURE THAT THE REFERRAL IS PUT INTO PLACE TO SEE THE DOCTOR. ALL COPAYS AND ANY FEES FOR SERVICE DUE TO NO INSURANCE ARE DUE PRIOR TO SEEING THE DOCTOR. Cash, check, or credit cards are accepted.

You will be seeing Dr. Hettiarachchi for urology problems. Therefore, it is very important that you are able to give a urine specimen at the time of your arrival to the office.

Your appointment is scheduled on _____ at _____.

Thank you for your cooperation. We look forward to your visit with us and should you have any questions, please give us a call.

I AGREE WITH THE ABOVE TERMS

Signature

Dr. John Hettiarachchi, DO, FACS

200 West Park Circle, Suite A • North Wilkesboro, NC 28659 • Tel: 336-838-5655 • Fax: 336-838-7556 • piedmonturology.net

Piedmont Urology

Patient Information (Please Print)

Date: _____

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

City / Town: _____ State: _____ Zip / Postal Code: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

Mobile Phone: _____ - _____ - _____

Date of Birth: _____ SSN: _____ Gender: M / F

Primary Care Physician: _____

Referring Physician: _____

Marital Status: (Circle One) Single / Married / Divorced / Separated / Widowed

Employer: _____

Employer Address: _____

City / Town: _____ State: _____ Zip / Postal Code: _____

Preferred Pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Emergency Contact

Last Name: _____ First Name: _____ MI: _____

Address: _____

City / Town: _____ State: _____ Zip / Postal Code: _____

Home Phone: _____ - _____ - _____ Work Excuse: _____ - _____ - _____

Mobile Phone: _____ - _____ - _____

Relationship to Patient: _____

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Patient History and Review of Systems

Date: _____ Patient Name: _____

Personal History: Please answer all of the following questions:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> Children # _____
Alcohol Use: <input type="checkbox"/> No <input type="checkbox"/> Yes: How Often?
Smoking: <input type="checkbox"/> No <input type="checkbox"/> Yes: How Much?
Do you have a history of drug abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes: Substance Abused:
Are you sexually active? <input type="checkbox"/> No <input type="checkbox"/> Yes
Please list all allergies below:
Please list any past medical history below:
Please list any past surgeries and the year they were completed:
Family History: Is there any family history of the following? <input type="checkbox"/> Stroke <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Arthritis <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hemophilia <input type="checkbox"/> Lung Disease <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Incontinence <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Bladder Cancer <input type="checkbox"/> Kidney Cancer <input type="checkbox"/> Cancer (type) _____

Review the following list and check all that apply:

	Current	Past		Current	Past		Current	Past
HEAD AND NECK			HEART AND CIRCULATION			KIDNEYS & BLADDER		
Headaches			High Blood Pressure			Frequent Urination		
Fevers/Chills			Chest Pain/Tightness			Kidney Stone		
Hay Fever			Swelling Feet & Legs			Kidney/Bladder Infection		
EYES			Leg Cramps/Pain			Difficulty Urinating		
Vision Problems			Stroke			Painful Urination		
Glasses			SKIN			Blood in Urine		
Neurological			Rashes			Hesitancy		
Numbness in Extremities			Itching			Incomplete Emptying		
Seizure			MUSCLES AND JOINTS			Leaking or Dribbling		
Dizziness/Vertigo			Joint Pain/Swelling			Urinating at Night		
Depression/Nervousness			Muscle pains			Incontinence		
Excessive Tiredness			Back Pain			Split Stream		
DIGESTIVE			EARS / NOSE / THROAT			Urgency		
Stomach Pains			Sinus Problems			Respiratory		
Constipation			Sore Throat			Cough		
Digestion/Swallowing			Hearing Loss			Asthma		
Diarrhea			Earaches			Emphysema		
Nausea/Vomiting						Shortness of Breath		
Severe Weight Loss			Other:					
Anemia or Low Blood								
Cups of coffee / Tea / Soda How many per day?								

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Piedmont Urology
Authorization to Release Information

Date: _____

I, _____ hereby authorize

_____ Phone: _____

Fax: _____ to release any information in the
course of examinations and treatments to:

Piedmont Urology, PLLC
John Hettiarachchi, DO, FACS
200 West Park Circle, Suite A
North Wilkesboro, NC 28659

Signature: _____

Witness: _____

Patient Information:

Name: _____

Date of Birth: _____

Social Security Number: _____

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HIPAA Information Release Form

The **Health Insurance Portability and Accountability Act** has set restrictions on how your health information is maintained and who has access to the information.

You are the patient of **Piedmont Urology, PLLC**, you can decide who can receive information about your health and / or medical information from the office. It is the goal of Piedmont Urology to meet these requirements, as well as allow you to **designate an individual(s), if you so choose**, that you feel may be of benefit in managing your health care. This individual may receive information about test / lab results, diagnosis, medications, appointments, referrals, or other information. However, you are not required to make a designation.

*****THIS IS NOT A HEALTH CARE POWER OF ATTORNEY DECLARATION FORM!**

Designated Person	Relation to Patient	Phone Number	Address

The office can disclose my health information to the people I have designated who are involved in my care. I understand that I may change the individuals on the list at anytime by signing a new form.

Patient
Signature: _____ Date: _____

Witness: _____ Date: _____

