UROLOGIC SOLUTIONS
AFTAB HUSAIN, M.D., P.A.
PERTH AMBOY, NJ 08861
PH (732)826-0059
FX (7320826-6576
UROLOGICSOLUTIONS@GMAIL.COM

PATIENT INFORMATION FORM

PRIMARY DOCTOR:_____ CARDIOLOGIST _____

ALLERGIES:_____ PHARMACY _____

MALE/ FEMALE

LAST NAME:_____FIRST NAME:_____M.I____

DATE OF BIRTH:___/____/____ AGE:_____ SOCIAL SECURITY:_____

ADDRESS:_____CITY:_____STATE_____

ZIPCODE:_____ E-MAIL:_____

HOME PHONE:_____MOBILE:_____OTHER:_____

MARITAL STATUS: S__M__D__W__ NAME OF SPOUSE:_____

IN CASE OF AN EMERGENCY NOTIFY:_____

TELEPHONE:_____ RELATIONSHIP:_____

****

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MYSELF OR THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED.

RELEASE OF INFORMATION:

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNATURE:_____DATE:_____

DATE: _____

UROLOGIC SOLUTIONS
AFTAB HUSAIN, M.D., P.A.
PERTH AMBOY, NJ 08861
PH (732)826-0059
FX (7320826-6576
UROLOGICSOLUTIONS@GMAIL.COM

FINANCIAL CONSENT

I, _____, understand that I am or will be responsible for all

charges associated with today's visit and any subsequent visits relating to the diagnosis, testing and treatment of any and all conditions, including but not limited to the following items:

- NO REFERRAL AT THE TIME OF VISIT: If you did not bring a valid referral at the time of your visit and still wish to be seen, you will be responsible for all charges. It is your duty to know if your insurance requires a referral for specialists.
- DEDUCTIBLE: You are responsible to pay your deductible. If a claim is applied towards your deductible, it is your responsibility to pay it. There will be no exceptions made to this.
- COPAYMENTS: All copayments are due at the time of your visit, before you are seen.
- NO INSURANCE: You will be responsible for all associated with all types of visits. This includes Physician consultations, follow up visits, lab visits, radiology visits, and office procedures.
- WORKMEN'S COMPENSATION: Our office does not accept worker's compensation insurance. Please notify the staff if your visit is related to any worker's compensation. If your insurance carrier does not pay any claims due to worker's compensation, then you are responsible for the bill.
- CHANGES IN INSURANCE: If there is a change in your insurance and you failed to inform the office staff then you are responsible for any denied claims.
- DELINQUENT ACCOUNTS: You may be denied visits to the physician if your account is
- delinquent. In the event that your account is delinquent, you will be responsible for any
- collection fees associated with your account.
- MISSED APPOINTMENTS: In the event that you have missed an appointment and failed to inform the office staff without 24 hour notice, you will be responsible for a $25.00 fee.

SIGNATURE: _____

AFTAB HUSAIN, MD
AMERICAN BOARD OF UROLOGY
WWW.UROLOGICSOLUTIONS.COM

Patient Name: _____ **Date of Birth**: _____

Height: _____ **Weight**: _____

Medical History: (Please circle all that apply)

Anxiety	Coronary Artery Disease	Hepatitis
Arthritis	Depression	High Blood Pressure
Thyroid Problems	GERD	Congestive Heart Failure
Asthma	Diabetes	High Cholesterol
Atrial Fibrillation	Renal Disease	History of HIV/AIDS
Bone Marrow Transplant	Lymphoma	COPD
Hearing Loss	Stroke	Mitral Valve Replacement
Stents	Pacemakers	Prostate Cancer
Anemia	Gallbladder Disease/Stones	Other Cancer:
Radiation Treatment; if so, where?		
Other Medical History:		

Past Surgical History: (Please list all below)

_____
_____
_____
_____
_____

Patient Name: _____ **Date of Birth**: _____

Urologic Conditions: (Please circle all that apply)

Overactive bladder	Urinary Urgency	Urinary Tract Infection (UTI)	Bladder Cancer
Prostate Cancer	Incontinence	Erectile Dysfunction	Blood in Urine
Varicocele	Prostatitis	Bladder stones	Urethral Obstruction
Urinary Retention	Painful Urination	Kidney Stones	Slow Urination
Urine Leakage	Premature Ejaculation	Interstitial Cystitis	Hydronephrosis
Other:			

Medications: (Please enter all current medications including dosage and frequency)

_____ Dose: _____ Freq: _____
_____ Dose: _____ Freq: _____
_____ Dose: _____ Freq: _____
_____ Dose: _____ Freq: _____
_____ Dose: _____ Freq: _____
_____ Dose: _____ Freq: _____
_____ Dose: _____ Freq: _____

Allergies: (Including any medication allergies)

_____
_____

Social History:

Smoking	Alcohol	Marital Status	Children?
Current Smoker	None	Single	0
Never Smoked	Less than 1 per day	Married	1
Former Smoker	1-2 drinks per day	Divorced	2
Other:	3 or more drinks per day	Separated	3
	Other:	Widowed	Other:

Family History: (Please include family history of any medical conditions)

_____
_____