Steven A. Johnson, M.D., P.A.

Patient information				
Full Name: Last:	First:	Middle:	(Maiden):	
Address:	City:	State:	Zip:	
Sex (check one): ☐ Male ☐ Female	Date of Birth:	Age:	Social Security #:	Driver's License #:
Home Phone #: ( )	Cell Phone #: ( )	Work Phone #: ( )	Email Address:	
Marital Status (check one): ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated			Spouse's Name:	
Race (check one): ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other				
Occupation:	Employer:	Status (check one) ☐ Full Time ☐ Part Time ☐ Retired		
If Patient is a Minor, provide Name of Parent(s) or Legal Guardian:				
Emergency Contact (not living at the same address)		Emergency Contact Phone #: ( )		
How did you hear about the physician you are seeing today? ☐ Physician Referral Who?_____ ☐ Other Professional ☐ Existing Paitent ☐ Family ☐ Friend ☐ Word of Mouth ☐ Health Plan/ Insurance Company ☐ Emergency Room ☐ Other				

Responsible Party (only to be completed if patient is a minor)				
Full Name: Last:	First:	Middle:	(Maiden):	
Address:	City:	State:	Zip:	
Sex (check one): ☐ Male ☐ Female	Date of Birth:	Age:	Social Security #:	
Home Phone #: ( )	Cell Phone #: ( )	Work Phone #: ( )	Email Address:	
Employer:		Relationship to Patient:		

Insurance Information			
Primary Insurance Company:		**Secondary** Insurance Company:	
Policy Holder (if other than patient):	Date of Birth:	Policy Holder (if other than patient):	Date of Birth:
Social Security #:	Relationship to Patient:	Social Security #:	Relationship to Patient:
Policy Holder's Employer:	Employer Phone #:	Policy Holder's Employer:	Employer Phone #:
Policy Holder currently working (check one): ☐ Yes ☐ No		Policy Holder currently working (check one): ☐ Yes ☐ No	

I authorize the physcian to medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim.

I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to the physician. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Patient:_____ Date:_____

Signed By:_____ ☐ Parent ☐ Guardian

Steven A. Johnson, M.D. P.A.

Last Name	First Name	MI	Date of Birth

REVIEW OF SYSTEMS

Have you ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/illnesses that you have checked below? ____ Yes ____ No

SYSTEM	NO	YES	SYSTEM	NO	YES	GI	NO	YES
Urinary			**Respiratory**			Stomach Ulcers		
Kidney disease			Asthma			Rectal bleeding		
Frequent infections			Pneumonia			Abdominal pain		
Incontinence			Bronchitis			Colon/Rectal cancer		
Blood in urine			Chronic cough			**Ear,Nose & Throat**		
Difficulty urinating			Hoarseness			Nosebleeds		
Dribbling			Tracheotomy			Deafness		
Bladder Prolapse			**Hematological**			**Ophthalmic**		
Burning w urination			Bleeding disorder			Cataracts		
Bladder cancer			Anticoagulant use			Glaucoma		
Kidney stones			**Endocrine/Metabolic**			Blindness		
Back pain			Diabetes			**Breast**		
Decreased libido			Thyroid Disorders			Lumps		
Male:			**Neurological**			Cancer		
Elevated PSA			Seizures			**Psychosocial**		
Prostate cancer			Previous stroke			Alcoholism		
Erectile dysfunction			**Musculoskeletal Disease**			Substance abuse		
Date of last PSA			Muscle Disease			Depression/Anxiety		
Cardiac			Arthritis			**Symptom/Disease not listed above:**		
High blood pressure			**Skin**					
Low blood pressure			Rash					
Irregular heartbeat			Bruises					
Chest pain								

PAST HISTORY

Have you ever had surgery or been hospitalized? No_____ Yes_____	**Surgeries** **Dates**	**Other Hospitalizations & Date**
Have you had any problems with anesthesia? No_____ Yes_____ List below:		

Are you currently or have you ever used any tobacco or alcohol products? No_____ Yes_____
Alcohol: How many drinks per day_____ per week_____ per month_____
Tobacco: How many packs per day_____ For how many years?_____
Are you or have you ever used recreation/illicit drugs? No_____ Yes_____
If yes, what kind?_____ For how long?_____

List all MEDICATIONS currently taking and dosage:

DRUG ALLERGIES

FAMILY HISTORY: Indicate if your parents, siblings or children have had any of the following conditions:

Condition	*NO*	*YES*	*Relation*	*Condition*	*NO*	*YES*	*Relation*
Prostate Cancer				Ovarian Cancer			
Bladder Cancer				Heart Disease			
Kidney Cancer				High Blood Pressure			
Kidney problems				Breast Cancer			

Steven A. Johnson, M.D.

ADULT & PEDIATRIC UROLOGY

Steven A. Johnson, M.D.
Diplomate, American Board of Urology

***Angela Reynolds*, FNP-BC**
Family Nurse Practitioner-Certified

Randee Hallmark, FNP-C
Family Nurse Practitioner-Certified

Patient Consent Form

I understand that as part of the provision of the healthcare services, Steven A. Johnson, M.D., P.A. creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more completed description of the uses and disclosures, of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes, I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not require to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

2. A photocopy of fax of this consent is as valid as this original.

3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

4. I have the right to request that the use of my Protected Health Information which is used or disclosed for the purposes of treatment payment or health care operations be restricted. Steven A. Johnson, M.D., P.A. is not bound by the restriction unless it is in agreement with the restriction.

PLEASE SIGN AND RETURN FOR OFFICE RECORDS.

_____ _____

Patient's Name Printed Date

_____ _____

Patient's Signature (Or Guardian, if Minor) Social Security Number

600 E. Taylor St., Suite 201 • Sherman, Texas 75090 • VOICE 903.957.1104 • FAX 903.957.1105

Please visit our website at sajurology.com

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ADULT & PEDIATRIC UROLOGY

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Family Nurse Practitioner-Certified

Randee Hallmark, FNP-C
Family Nurse Practitioner-Certified

I_____ authorize the following person(s) to access my medical records or speak to staff of Steven A. Johnson, M.D., P.A. regarding care or on my behalf. This will be in effect from the date signed on this authorization.

I understand this is an authorization to allow the parties below to discuss my appointments, treatment of care, lab results. Test results and any other information obtained at Steven A. Johnson, M.D., P.A.

_____
Authorized Party

_____
Relationship to Patient

_____
Authorized Party

_____
Relationship to Patient

Any limitations to access your records must be listed below.

_____

_____

_____

_____ _____
Patient Signature Date Signed

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