

# William Holt Sanders

Diplomat American Board of Urology  
Urologic Oncology  
Adult Urology

## Patient Information Form

Today's Date \_\_\_\_\_  
Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Patient's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Beeper \_\_\_\_\_ E-Mail \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Spouse/Nearest Relative \_\_\_\_\_ Phone \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_  
Physician's Address \_\_\_\_\_ Physician's Phone \_\_\_\_\_

## Spouse or Parental Information (This may be important for filing insurance)

Spouse's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
Spouse's Employer Name \_\_\_\_\_  
Employer Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## Insurance

Primary Insurance Name \_\_\_\_\_  
Claims Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Name of Person Holding Insurance \_\_\_\_\_  
Relationship of Patient to Insured \_\_\_\_\_  
Secondary Insurance Name and Address \_\_\_\_\_  
Secondary Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Name of Person Holding Insurance \_\_\_\_\_  
Relationship of Patient to Insured \_\_\_\_\_

I authorize the release of any medical information necessary to process any insurance claims and also authorize payment of medical insurance benefits to the physician for medical services.

\_\_\_\_\_  
Patient's Signature and Date

\_\_\_\_\_  
Insured's Signature and Date

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_

Widowed \_\_\_\_\_

What is the reason for your visit: \_\_\_\_\_

Please circle yes or no for all questions:

Frequent Urination Daytime	Y	N	Difficulty Starting Urination (Hesitancy)	Y	N
Frequent Urination Nighttime	Y	N	Weak Stream	Y	N
Urgency	Y	N	Feeling of Incomplete Bladder Emptying	Y	N
Burning with Urination	Y	N	Leaking of Urine (Incontinence)	Y	N
Vaginal Burning	Y	N	Spraying of Urinary Stream	Y	N
Lower/Abdominal Pressure/pain	Y	N	Penile/Vaginal Discharge	Y	N
Back/Flank Pain	Y	N	Difficulty achieving or maintaining an erection		
Blood in Urine	Y	N	(impotence)	Y	N
Bladder Infections	Y	N			

**LIST ALL PRIOR SURGERIES**

Surgery: _____	Hospital: _____	Date: _____
Surgery: _____	Hospital: _____	Date: _____
Surgery: _____	Hospital: _____	Date: _____
Surgery: _____	Hospital: _____	Date: _____
Surgery: _____	Hospital: _____	Date: _____

Do you have:

Fever	Y	N	Nausea	Y	N	Depressed Mood	Y	N
Weight gain/loss	Y	N	Diarrhea	Y	N	Nervous Disorder	Y	N
Poor Vision	Y	N	Muscle or joint pain	Y	N	Are you always hungry	Y	N
Chest Pain	Y	N	Rash	Y	N	Always thirsty	Y	N
Shortness of Breath	Y	N	Leg or arm weakness	Y	N	Always hot	Y	N

Circle Y or N for all questions. Do you have or have you ever had:

Atrial Fibrillation	Y	N	Joint Replacement	Y	N
Asthma	Y	N	Kidney Disease/Stones	Y	N
Blood Clotting Disorder	Y	N	Latex Allergy	Y	N
Cancer (Type) _____	Y	N	Mitral Valve Prolapse	Y	N
Diabetes	Y	N	Parkinson's Dis./Multiple Sclerosis	Y	N
Heart Disease/Arrhythmia	Y	N	Stroke	Y	N
Heart Valve Replacement	Y	N	Thyroid Disorder	Y	N
Hepatitis	Y	N	Tuberculosis	Y	N
HIV Positive	Y	N	Autoimmune Disorder (fibromyalgia)	Y	N
High Blood Pressure	Y	N	Stomach Ulcers	Y	N
Arthritis	Y	N	Emphysema	Y	N
High Cholesterol	Y	N	Glaucoma	Y	N

List all daily medication(s) and dosages:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

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

How many natural children do you have? \_\_\_\_\_

Have you ever smoked Cigarettes Y N How many packs a day? \_\_\_\_\_

Do you still smoke? \_\_\_\_\_

When did you quit? \_\_\_\_\_

How many alcoholic beverages do you consume per day? \_\_\_\_\_

Are you parents alive? \_\_\_\_\_ How old are they? Father \_\_\_\_\_ Mother \_\_\_\_\_

If not, how old were they when they died? Father \_\_\_\_\_ Mother \_\_\_\_\_

Does any member of your family have the following? yes\_\_\_ no\_\_\_ If yes, who?

Kidney Cancer \_\_\_\_\_ Bladder Cancer \_\_\_\_\_

Prostate Cancer \_\_\_\_\_ Kidney Stones \_\_\_\_\_

**William Holt Sanders, M.D., P.C.**

**Receipt of Notice of Privacy Practices  
Written Acknowledgement form**

An official copy of **William Holt Sanders, M.D., P.C.**'s Notice of Privacy Practices is located in a black binder in our lobby. A copy is available upon request.

I, \_\_\_\_\_, have been given an opportunity to review a copy of **William Holt Sanders, M.D., P.C.**'s Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

## CONSENT FORM

**Consent for Treatment** : I give consent to my physician, other attending physicians and their assistants and designees, to provide me with such medical, surgical, diagnostic, or other treatment services judged necessary an/or appropriate. This consent includes my consent for diagnostic procedures and all medical treatment rendered at my physician's office under his/her instruction: including x-ray, laboratory procedures and other tests, treatments or medications, monitoring, and all other procedures or treatments that do not require my specific informed consent.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Confidential Information**: Title II of The Health Insurance Portability and Accountability Act (HIPPA) establishes national standards for providers, insurance plans and employers in attempt to control fraud and abuse in the health system. As part of Title II of HIPPA we are required to obtain your social security number and a copy of your driver's license as a photo ID. This is an important step to prevent fraud as we interact with insurance companies and wit the Medicare administration.

If you would prefer not to provide this information, we can accommodate you be letting you pay in full for the service being provided at the time it is rendered, and we will provide you with the necessary forms needed to file your claim with your insurance company.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Financial Agreement  
(All patients)

Initial \_\_\_\_\_

**Copays**

Many insurance plans require that patients pay a co-payment at the time of service. We are not allowed to defer, waive, or disregard these payments. Please be prepared to settle these charges at the time of your visit. We accept cash, VISA, MasterCard, AMEX, Discover, and personal checks. Returned checks will be charged an additional fee of \$30.00.

Initial \_\_\_\_\_

**Medical Records**

There is a fee for medical records and preparation of \$40.00 to attorneys, insurance companies, etc, (this fee may or may not change dependant upon all requested). To alleviate any extra expenses, we offer a 1 time annual fee of \$15.00 for medical records request, which will allow medical records to be prepared and sent to any party you request without any additional charges.

Initial \_\_\_\_\_

**Accounts Past Due**

If a payment to your account is not received after 3 billing cycles, your account will be turned over to a collection agency, American Credit Bureau, and there will be a blemish on your credit report reflecting this balance. You will be responsible for the outstanding balance and the legal and collection agency fees associated with the collection process. All delinquent accounts can bear interest at the legal rate.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Medicare Extended Authorization**  
(Medicare patients only)

I request that payment of authorized Medicare benefits be made on my behalf to William Holt Sanders, M.D. for any services furnished to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Also due to the non covered services and procedures not covered by Medicare, I will be responsible for any charges after normal processing of insurance(s) that is not covered.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Medicare Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
WILLIAM HOLT SANDERS, M.D.

Fellow of the American College Of Surgeons  
Specializing in Adult Urology