RUSSELL DOUBRAVA, D.O.

2451 S. FM 51
Suite 100
Decatur, TX 76234

Phone: 940-627-0088
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Board Certified in the Surgical & Medical Treatment of Urologic Diseases

Patient's Name: (last) _____ (first) _____ (mi) _____
Date of Birth: _____ Age_____ Sex: Male Female
Social Security # _____ Marital Status_____
Mailing Address: _____
City _____ State _____ Zip _____
Primary Phone: _____ ☐ home ☐ cell ☐ work
Secondary Phone: _____ ☐ home ☐ cell ☐ work
** Do you want to receive text message alerts for appointment reminders? ☐ yes ☐ no
Email Address: _____ (needed to access Patient Portal)
Pharmacy Name: _____ Pharmacy Location _____
Referring Physician: _____ Physician Phone _____
Family Physician: _____ Physician Phone _____

Responsible Party: If other than self (ie. spouse or parent).
Parent/Legal Guardian_____ Relationship _____
Date of Birth: _____ Primary Phone: _____
Address: _____ City _____ State _____ Zip _____

Primary Insurance Company: Insurance Card must be presented at time of appointment.
Insurance Name_____ Policy ID # _____

Secondary Insurance Company: Insurance Card must be presented at time of appointment.
Insurance Name_____ Policy ID # _____

Emergency Contact Information:
Name: _____ Relationship_____
Home Phone: _____ Cell Phone: _____

Allergies – Do you have any medication allergies? **YES / NO**
Please list **ALL** types (drug, environmental, food, latex, etc.)
_____
_____

Current Medications – Please list **ALL** medications (including over the counter) you are currently taking or attach a list of your current medications:

Drug Name w/ Strength	**Drug Name w/ Strength**	**Drug Name w/ Strength**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Clinical Staff Notes Only:

Vitals:
Weight: _____
Height: _____
BP: _____
Pulse: _____
Resp: _____
Temp: _____

Lab Orders:
UA **BMP**
C&S **CMP**
Cytology **CBC**
PSA **Testosterone**
Other: _____
_____

Rx/Samples:
_____
_____

Return Visit:
_____
_____

Other Orders / Notes:
_____
_____

PLEASE EXPLAIN THE REASON FOR YOUR VISIT

Why are you seeing the doctor today? _____
How long have you had this problem? _____
Is the problem/pain continuous or does it come and go? _____
Describe any pain you are having (sharp, dull, burning, etc.). _____
Please explain if you have had any previous treatment for this problem? _____

REVIEW OF SYSTEMS Please **CIRCLE** any symptoms you are **currently having**:

Constitutional
Aches/Pains
Appetite Changes
Bruises Easily
Chills
Fever
Generalized Weakness
Weight Loss

Eyes
Blurred Vision
Double Vision

Allergies
Drug
Environmental
Latex
Other

Neurological
Balance Problems
Dizzy Spells
Numbness/Tingling
Tremors

Endocrine
Diabetes
Excess Thirst

Gastrointestinal
Abdominal Pain
Constipation
Fecal Incontinence
Indigestion/Heartburn
Nausea/Vomiting

Cardiovascular
Chest Pain/Angina
Difficulty Breathing
Swelling

Skin
Persistent Itch
Skin Rash

Musculoskeletal
Back Pain
Joint Pain

Respiratory
Frequent Cough
Shortness of Breath

Hematic/Lymph
Bleeding Problems

Psychological
Anxious
Depressed
Other

PAST MEDICAL HISTORY Please **CIRCLE** if you **have** or **have had** any of the following:

Cardiovascular
Aortic Aneurysm
Arrhythmia
Atrial Fibrillation
Bleeding Disorder
Congestive Heart Failure
Deep Vein Thrombosis
Heart Attack
High Blood Pressure

Endocrine/Metabolic
Diabetes Type 1
Diabetes Type 2
Gout
Hyperthyroidism
Hypothyroidism

General
Allergies
High Cholesterol
HIV
Obesity

Gastrointestinal
Diverticular Disease
GERD
Hepatitis
Irritable Bowel

Genitourinary
BPH
Bladder Cancer
Decreased Renal Function
Elevated PSA
Kidney Disease
Kidney Stones

Gyn/OB
Osteoporosis

HEENT
Cataracts
Glaucoma

Musculoskeletal
Arthritis
Back Pain
Fibromyalgia

Neurological
Alzheimer's Disease
Anxiety Disorder
Depression
Parkinson's Disease
Stroke

Respiratory
Asthma
COPD
Pulmonary Embolism

Tumors/Cancer
Indicate Status:
Current **(C)**
or History of **(H)**
Breast Cancer - C / H
Colon Cancer - C / H
Lung Cancer - C / H
Prostate Cancer - C / H
Skin Cancer - C / H

Other
_____
_____

SURGICAL HISTORY Please **CIRCLE** any surgery you **have had** and include the date of procedure:

Abdomen
Appendix
Bariatric - Gastric Bypass/
Lap Band / Sleeve / Other
Colon Resection
Colonoscopy
Gallbladder
EGD
Hemorrhoid
Hernia - Hiatal / Inguinal /
Umbilical / Other
Other: _____

Heart/Blood Vessels
Aortic Aneurysm Repair
Heart Bypass (CABG)
Heart Stents
Pacemaker Insertion
Other: _____

Lungs
Lung Surgery (L / R / Bilateral)
Explain: _____

Kidney
Nephrectomy -
Partial (L / R / B)
Radical (L / R / B)
Kidney / Ureteral Stone -
ESWL (Shockwave)
Stone Removal
Other: _____

Bladder
Bladder Tumor Removal
Bladder Dilation
Urethral Stricture Dilation
Other: _____

Penis/Scrotum
Circumcision
Hydrocele (L / R / B)
Orchiectomy (L / R / B)
Spermatocele (L / R / B)
Varicocele (L / R / B)
Other: _____

Pelvic (female)
Bladder Lift (Sling)
Delivery - Vaginal
C-Section
Hysterectomy -
Abdominal or Vaginal
Ovaries (L / R / B)
Other: _____

Breasts
Breast Biopsy (L / R / B)
Breast Implant (L / R / B)
Lumpectomy (L / R / B)
Mastectomy (L / R / B)
Other: _____

Arms/Legs/Etc
Hand/Wrist (L / R / B)
Hip (L / R / B)
Knee (L / R / B)
Shoulder (L / R / B)
Other: _____

Prostate
Biopsy
Brachytherapy
PVP (Greenlight)
TUMT (Microwave)
TURP (Roto Rooter)
Other: _____

Head/Neck
Cataract (L / R / B)
Thyroid
Tonsillectomy
Other: _____

Spine
Neck
Back
Other: _____

Other
_____
_____

Date of Last Pneumonia Vaccine: _____ (administered every 5 years)
Date of Last Colonoscopy: _____

FAMILY HISTORY Please **CIRCLE** if anyone in your family **has had** any of the following, if yes, indicate which family member (Mother, Father, Siblings, etc.):

Bladder Cancer	Diabetes	Kidney Stones	Skin Cancer
Breast Cancer	Heart Attack	Lung Cancer	Stroke
Cancer (Site Unknown)	Kidney Cancer	Multiple Sclerosis	Other: _____
Colon Cancer	Kidney Disease	Prostate Cancer	_____

SOCIAL HISTORY

Marital Status: _____ **Children:** _____

Occupation: _____

Alcohol Consumption: □ None □ Social □ Light □ Moderate □ Excessive
□ Former Drinker When did you stop? _____ How much did you drink per day? _____

Tobacco Consumption: □ None □ Smokeless Tobacco □ Current Smoker Packs/day #____
□ Former Smoker When did you stop? _____ How much did you smoke? Packs/day #____

Caffeinated Beverages: □ None □ 1 Daily □ 2 Daily □ 3 Daily □ 4+ Daily

Recreational Drugs: □ None □ Amphetamine □ Heroin □ Marijuana □ Other

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AUTHORIZATIONS, CONSENTS AND AGREEMENTS

CONSENT TO TREATMENT: I, the undersigned, as the patient or on behalf of the patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in judgments of the treating physician. I am free to ask questions about such treatment and testing. I understand that no guarantee or assurance has been made as to the result that may be obtained.

FINANCIAL AGREEMENT: I hereby guarantee payment of services rendered. I understand that should any portion of the bill remain unpaid, it may result in collection activity. I further understand that I will be responsible for court costs, attorney fees and agency fees which may be incurred.

ASSIGNMENT OF BENEFITS: I hereby authorize all insurance companies to pay directly to Russell Doubrava, DO and any ancillary providers, any benefit and fees under my insurance policy or policies. I understand that this does not relieve me of my obligation to pay my account, co-payments, co-insurance and deductibles. Any balance that is not covered or paid by the insurance company is my financial responsibility.

RELEASE OF MEDICAL INFORMATION: I hereby consent and authorize Russell Doubrava, DO, affiliates or agents, to release any medical information in connection with the services rendered for determination of benefits, or for collection of said benefits from my health insurance carrier(s) and or other parties responsible for payment.

MEDICARE BENEFICIARIES ONLY: I certify that the information given in applying for payment under Title XVII of the Social Securities Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made directly to Russell Doubrava, DO. I understand that I am responsible for health insurance deductibles and co-insurance.

MEDICARE SUPPLEMENTS: I further authorize Russell Doubrava, DO to claim and receive benefits through my Medicare Supplement. This authorization includes claims of Medigap Benefits. This authorization shall remain in effect until and unless revoked in writing.

I HAVE READ THE AUTHORIZATIONS, CONSENTS AND AGREEMENTS, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE.

I, the undersigned, as the patient or on behalf of the patient, have been given the opportunity to receive and read a copy of Russell Doubrava, DO's Notice of Privacy Practices

_____	_____	_____
Signature of Patient/Representative	Name of Patient (Print)	Date

Acknowledgment of Notice of Privacy Practices

Russell Doubrava, D.O. reserves the right to modify the privacy practices outlined in the notice.

❑ I have received a copy of the notice of privacy practices for Russell Doubrava, D.O.

_____	_____	_____
Signature of Patient/Representative	Name of Patient (Print)	Date

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Authorization Form for Use and Disclosure of Protected Health Information

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

Persons to Whom Information May Be Disclosed: (ex: spouse, family members)

_____ _____
Name of person/organization Name of person/organization

_____ _____
Name of person/organization Name of person/organization

Information To Be Released: I authorize the disclosure of the following types of records created.

___Billing Records ___Medical Records ___Appointment Info ___Medication Reports

___All of the Above

Persons Authorized to Use or Disclose Information: Russell Doubrava, D.O.
2451 S. FM 51, Suite 100
Decatur, TX 76234

Expiration Date of Authorization: This authorization is effective until revoked/terminated by the patient or patient's representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Russell Doubrava, D.O. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of privacy of this information once Russell Doubrava, D.O. discloses it to another party.

Rights of the Individual:

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment.

_____ _____ _____
Signature of Patient/Representative Name of Patient (Print) Date