

## RUSSELL DOUBRAVA, D.O.

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Decatur, TX 76234

Board Certified in the Surgical & Medical Treatment of Urologic Diseases

Patient's Name: (last)			(first) _			(mi)
Date of Birth:		Age		Sex:	Male 1	
Social Security #					ital Status_	
Mailing Address:						
City		State	Zip			
Primary Phone:						
Secondary Phone:						
** Do you want to receive						)
Email Address:						
Pharmacy Name:			Pha	rmacy I	Location _	
Referring Physician:						
Family Physician:				sician P	hone	
Dagnangible Dauty, If a	than than gal	lf (io anousa o	m mamant)			
Responsible Party: If of		` •		Da	lationahin	
Parent/Legal Guardian		Deim	Dhono.	Re	erauonsnip	
Date of Birth:						
Address:		City	у		state	<b>z</b> ıh
Primary Insurance Con	npany: Ins	urance Card	must be pre	esented	at time of	appointment.
nsurance Name						
Secondary Insurance Co	omnany. Ir	surance Care	l must he n	roconto	d at time	of annointment
insurance Name			_			
insurance rvaine			101109	<i>"</i>		
Emergency Contact Info						
Name:						
Home Phone:			Cell Phon	e:		
Allamaiaa Da way hawa		odion ollonoico	NEC / N	NO		
Allergies – Do you have				NO		
Please list <u>ALL</u> types (dr	ug, environ	mental, food, l	atex, etc.)			
Current Medications – 1	Please list A	LL medicatio	ns (includin	g over t	he counter	) you are currently
t				-		
·		u 1150 o1 j o	W1		01101	
Drug Name w/ Strength	n D	rug Name w/	Strength		Drug Nar	ne w/ Strength
nical Staff Notes Only:						
als:	Lab Orde	<u>rs:</u>	Rx/	<b>Sample</b>	<u>es:</u>	Return Vis
eight:	UA	<b>BMP</b>				
ight:	C&S	CMP				
<u> </u>	Cytology	CBC				
lse:	PŠA	Testosterone	e Oth	Other Orders / Notes:		
sp:						_
	Other:					
mp:	Other: _					

# 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**:

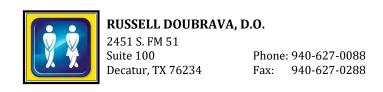
<b>Constitutional</b>	<u>Allergies</u>	<u>Gastrointestinal</u>	<b>Musculoskeletal</b>
Aches/Pains	Drug	Abdominal Pain	Back Pain
Appetite Changes	Environmental	Constipation	Joint Pain
Bruises Easily	Latex	Fecal Incontinence	
Chills	Other	Indigestion/Heartburn	<b>Respiratory</b>
Fever		Nausea/Vomiting	Frequent Cough
Generalized Weakness	Neurological	-	Shortness of Breath
Weight Loss	Balance Problems	<u>Cardiovascular</u>	
-	Dizzy Spells	Chest Pain/Angina	Hematic/Lymph
Eyes	Numbness/Tingling	Difficulty Breathing	Bleeding Problems
Blurred Vision	Tremors	Swelling	-
Double Vision		-	<b>Psychological</b>
	<b>Endocrine</b>	<u>Skin</u>	Anxious
	Diabetes	Persistent Itch	Depressed
	Excess Thirst	Skin Rash	Other

#### **PAST MEDICAL HISTORY** Please **CIRCLE** if you <u>have</u> or <u>have had</u> any of the following:

		<u>Respiratory</u>
Allergies	Osteoporosis	Asthma
High Cholesterol		COPD
HIV	<b>HEENT</b>	Pulmonary Embolism
Obesity	Cataracts	
	Glaucoma	Tumors/Cancer
<u>Gastrointestinal</u>		Indicate Status:
Diverticular Disease	<u>Musculoskeletal</u>	Current ( C )
GERD	Arthritis	or History of $(\mathbf{H})$
Hepatitis	Back Pain	Breast Cancer - C / H
Irritable Bowel	Fibromyalgia	Colon Cancer - C / H
		Lung Cancer - C / H
<u>Genitourinary</u>	<b>Neurological</b>	Prostate Cancer - C / H
BPH	Alzheimer's Disease	Skin Cancer - C / H
Bladder Cancer	Anxiety Disorder	
Decreased Renal Function	Depression	<u>Other</u>
Elevated PSA	Parkinson's Disease	
Kidney Disease	Stroke	
Kidney Stones		
	High Cholesterol HIV Obesity  Gastrointestinal Diverticular Disease GERD Hepatitis Irritable Bowel  Genitourinary BPH Bladder Cancer Decreased Renal Function Elevated PSA Kidney Disease	High Cholesterol HIV Obesity Cataracts Glaucoma  Gastrointestinal Diverticular Disease GERD Arthritis Hepatitis Irritable Bowel  Genitourinary BPH Alzheimer's Disease Bladder Cancer Decreased Renal Function Elevated PSA Kidney Disease  HEENT  Musculoskeletal Arthritis Back Pain Fibromyalgia  Neurological Alzheimer's Disease Briting Disease Briting Depression Depression Parkinson's Disease Stroke

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

<u>Abdomen</u>	<b>Kidney</b>		Pelvic (female)	<b>Prostate</b>
Appendix	Nephrectomy -		Bladder Lift (Sling)	Biopsy
Bariatric - Gastric Bypass/	Partial (L / R / B)		Delivery - Vaginal	Brachytherapy
Lap Band / Sleeve / Other	Radical (L / R / B)		C-Section	PVP (Greenlight)
Colon Resection	Kidney / Ureteral Stone -		Hysterectomy -	TUMT (Microwave)
Colonoscopy	ESWL (Shockwave	e)	Abdominal or Vaginal	TURP (Roto Rooter)
Gallbladder	Stone Removal		Ovaries (L / R / B)	Other:
EGD	Other:	_	Other:	
Hemorrhoid	<b>.</b>		<b></b>	Head/Neck
Hernia - Hiatal / Inguinal /	<u>Bladder</u>		Breasts (L. (B. (B.)	Cataract (L / R / B)
Umbilical / Other	Bladder Tumor Rem	oval	Breast Biopsy (L/R/B)	Thyroid
Other:	Bladder Dilation		Breast Implant (L / R / B)	· · · · · · · · · · · · · · · · · · ·
	Urethral Stricture Di		Lumpectomy (L / R / B)	Other:
Heart/Blood Vessels	Other:	_	Mastectomy (L / R / B)	
Aortic Aneurysm Repair			Other:	<b>Spine</b>
Heart Bypass (CABG)	Penis/Scrotum			Neck
Heart Stents	Circumcision		Arms/Legs/Etc	Back
Pacemaker Insertion	Hydrocele (L / R / B		Hand/Wrist (L / R / B)	Other:
Other:	Orchiectomy (L / R /	-	Hip (L/R/B)	
	Spermatocele (L / R		Knee $(L/R/B)$	<u>Other</u>
Lungs	Varicocele (L / R / I	•	Shoulder (L / R / B)	
Lung Surgery (L / R / Bilateral	) Other:	_	Other:	
Explain:				
Date of Last Pneumonia Va Date of Last Colonoscopy:			(administered ev	ery 5 years)
·			nily <u>has had</u> any of the follow (Mother, Father, Siblings,	•
Bladder Cancer Dia	betes	Kidne	y Stones Skin	Cancer
	art Attack		Cancer Strok	
	lney Cancer	_		r:
	-		te Cancer	
SOCIAL HISTORY				
Marital Status:	_ Childre	en:		
Occupation:				
<b>Alcohol Consumption:</b> □ Non □ Forn			rate $\square$ Excessive p? How much did	l you drink per day?
<b>Tobacco Consumption:</b> □ Non □ Form				# 1 you smoke? Packs/day #
<b>Caffeinated Beverages:</b> □ Non	ne 🗆 1 Daily 🗆 2 I	Daily	☐ 3 Daily ☐ 4+ Daily	
<b>Recreational Drugs:</b> None	□ Amnhetamine □	Heroir	n □ Marijuana □ Otho	e <b>r</b>



#### 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.

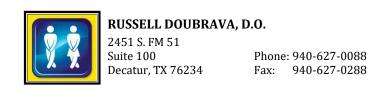
**RELEASE OF MEDICAL INFORMATION:** I hereby consent and authorize Russell Doubrava, DO, affiliates or agents, to release any medical information in connection with the services rendered for determination of benefits, or for collection of said benefits from my health insurance carrier(s) and or other 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 bel Russell Doubrava, DO's Notice of Privacy	. ,	pportunity to receive and read a copy of
	Name of Patient (Print)	 Date
Acknow	vledgment of Notice of Privacy Pr	actices
Russell Doubrava, D.O. reserves the right to mod	fy the privacy practices outlined in the notice.	
☐ I have received a copy of the notice of privacy p	practices for Russell Doubrava, D.O.	
Signature of Patient/Representative	Name of Patient (Print)	Date



### **Authorization Form for Use and Disclosure of Protected Health Information**

Patient Name:	Date of Birth:		
Persons to Whom Information May Be Dis	closed: (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	ne disclosure of the following types of records created.		
Billing RecordsMedical Record	rdsAppointment InfoMedication Reports		
All of the Above			
Persons Authorized to Use or Disclose Info	ormation: Russell Doubrava, D.O. 2451 S. FM 51, Suite 100 Decatur, TX 76234		
<b>Expiration Date of Authorization:</b> This authorization	zation is effective until revoked/terminated by the patient or patient's representative.		
<b>Right to Terminate or Revoke Authorization:</b> Russell Doubrava, D.O. You should contact the Pri	You may revoke or terminate this authorization by submitting a written revocation to vacy Officer to terminate this authorization.		
	disclosed under this authorization may be disclosed again by the person or organization re your right to the protection of privacy of this information once Russell Doubrava, D.O.		
Rights of the Individual:  • You may inspect or copy information used • You may refuse to sign this authorization.	or disclosed under this authorization. Your refusal will not affect your ability to obtain treatment.		
Signature of Patient/Representative	Name of Patient (Print)  Date		