BJORN SAUERWEIN, Ph.D., M.D.

500 S. 11TH Ave., Suite 301
Pocatello, Idaho 83201
208-233-3355

PATIENT INFORMATION

Name (Last, First, Initial) _____ Date_____
Address_____City_____ State_____ Zip _____
Home phone _____Work phone _____Cell Phone _____
S.S.# _____ Sex M / F Date of Birth_____
Email address_____

Marital Status:

[ ] Married [ ] Single [ ] Other [ ] Widowed [ ] Separated [ ] Divorced

Spouse/Parent's name _____Date of Birth _____

Emergency Contact _____Relationship _____Phone # _____

PRIMARY RESPONSIBLE PARTY (Statements will be sent to this person)

Name (Last, First, Initial) _____Relationship to Patient _____
Address_____City_____ State_____ Zip _____
Home phone _____Work phone _____Cell Phone _____
S.S.# _____ Sex M / F Date of Birth _____

Employment Status

[ ] Full Time [ ] Part Time [ ] Retired [ ] Unemployed [ ] FT Student [ ] PT Student

Employed by: _____ Phone Number _____

INSURANCE INFORMATION

Primary Insurance _____Effective Date _____
Address_____City_____ State_____ Zip_____
Policy Holder's Name _____Date of Birth _____ Sex M / F
Group #_____ Policy# _____
Employer _____

Secondary Insurance _____Effective Date _____

EMERGENCY COVERAGE

It is impossible for Dr. B. Sauerwein to provide 24/7 emergency coverage. There may be times when an emergent urological condition requires you to be seen by another physician and/or be transferred to a different hospital that is out of town for definitive care.

ASSIGNMENT AND RELEASE

____ Private Insurance (NON Medicare): I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I authorize the physician to release any information required to process this claim.

____MEDICARE/MEDICAID: I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished by Bjorn Sauerwein, PhD. M.D. including physician services. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date_____

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PATIENT, FAMILY AND SOCIAL HISTORY

Name_____ Date _____
Date of Birth _____ Age _____ Height_____ Weight _____
Race: _____ Hispanic/Latino: Y / N Language: _____
Referred By: _____ Primary Physician: _____ Pharmacy: _____

MEDICINE ALLERGIES:

_____
_____
_____
_____

LIST OF MEDICATIONS YOU TAKE: (If more room needed list on back) □ yes

_____ DOSE _____ MG _____
_____ DOSE _____ MG _____
_____ DOSE _____ MG _____
_____ DOSE _____ MG _____

DO YOU TAKE ASPIRIN EVERY DAY? Y / N

LIST ALL THE OPERATIONS OR SURGERIES THAT YOU HAVE HAD WITH THE DATE PERFORMED:

_____ DATE_____ _____ DATE_____
_____ DATE_____ _____ DATE_____
_____ DATE_____ _____ DATE_____

DO YOU SMOKE: *Every Day* *Former Smoker* *No* IF YOU QUIT GIVE DATE _____
DO YOU DRINK ALCOHOLIC BEVERAGES? *Yes* *Not Anymore* *No* IF YES, HOW MUCH & TYPE _____
HAVE YOU HAD A BLOOD TRANSFUSION? *Yes* *No* IF YES, GIVE DATE _____

HAVE **YOU** OR **ANY IMMEDIATE FAMILY MEMBER** BEEN TREATED FOR ANY OF THE FOLLOWING?

	YOU	**FAMILY (Please give relationship)**
ASTHMA		
EMPHYSEMA		
SHORTNESS OF BREATH		
HIGH BLOOD PRESSURE		
HEART ATTACK		
CHEST PAIN		
CROHNS/COLITIS		
PHLEBITIS		
CANCER (If yes, what type?)		
EASY BLEEDING		
DIABETES (if yes, what type?)		
STROKE		
BACK PAIN		
DEPRESSION		
BLOOD IN URINE		
KIDNEY DISEASE		
KIDNEY STONES		
KIDNEY FAILURE		
PROSTATE PROBLEMS		
URINARY INFECTIONS		
BLOOD CLOT/ PULMONARY EMBOLISM		
OTHER		

FAMILY HISTORY: LIST ANY FAMILY MEMBERS WHO HAVE BEEN DIAGNOSED AS HAVING ANY OF THESE ILLNESSES OR WHICH HAVE CAUSED THEIR DEATH.

PROSTATE CANCER_____KIDNEY CANCER _____
BLADDER CANCER_____TESTICULAR CANCER _____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I certify that I have been given an opportunity to read the ***"Notice of Privacy Practices"*** in this office.

I consent to the use or disclosure of my protected health information by Dr. B. Sauerwein for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct an operation/treatment by the doctor. I understand that a diagnosis or treatment of me, Dr. B. Sauerwein may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry our treatment, payment or healthcare operations of the practice. Dr. B. Sauerwein is not required to agree to the restrictions that I may request. However, if they agree to a restriction that I request, the restriction is binding on them.

My "***protected health information***" includes my demographic information, collected from me and created or received by my physician, another health care provider(s), a health plan, my employer or a health care clearing house. This information relates to my past, present or future, physical, mental health and/or condition and identifies me and/or if there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Dr. B. Sauerwein's ***Notice of Privacy Practices***, prior to signing this document. It describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations by him. This ***Notice of Privacy Practices*** also describes my rights and the rights of Dr. B. Sauerwein's duties with respect to my protected healthcare information.

Dr. B. Sauerwein reserves the right to change the privacy practices that are described in the ***Notice of Privacy Practices***. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy is sent in the mail or by asking for one at the time of my next appointment.

Dr. B. Sauerwein may release my healthcare information to:

Self only ☐ ***Other*** ☐ ***Name of person***:_____

Patient, Parent or Guardian Signature:_____

Date _____

I have the right to revoke this consent, in writing, at any time.