Arif H. Agha, M.D.

Vasectomy Specialist Clinics of Chicago

Phone: 312-473-7647 Fax: 630-990-4245

www.vasectomyspecialist.com

REGISTRATION INFORMATION

DATE: _____ **HOME PHONE:** _____ **CELL PHONE:** _____ **EMAIL:** _____

PATIENT'S NAME: _____
LAST FIRST MI

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SEX: _____M _____F **AGE:** _____Years **BIRTH DATE:** _____/_____/_____ **SS#:** _____ _____ _____- _____ _____- _____ _____ _____ _____

HEIGHT: _____' _____" **WEIGHT:** _____ Lbs **MARITAL STATUS:** _____ **SINGLE** _____ **MARRIED** _____ **DIVORCED** _____ **OTHER**

OCCUPATION: _____ **EMPLOYER:** _____ **PHONE:** _____

ADDRESS: _____ **CITY/ STATE:** _____ **ZIP:** _____

SPOUSE (OR RESPONSIBLE PARTY) NAME: _____ **EMPLOYED BY:** _____

BIRTH DATE: _____ **SS#:** _____ _____ _____- _____ _____- _____ _____ _____ _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ **RELATIONSHIP TO PATIENT:** _____

NAME OF PRIMARY INSURER: _____ **NAME OF SECONDARY INSURER:** _____

NAME OF YOUR PRIMARY DOCTOR: _____ **PHONE:** _____ **FAX:** _____

NAME OF YOUR DRUG STORE: _____ **PHONE:** _____ **FAX:** _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?: _____

PHONE: _____ **RELATIONSHIP TO PATIENT:** _____

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO **DR. ARIF H. AGHA, M.D.**
NAME OF INSURANCE COMPANY

ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEARBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

X_____ _____
SIGNATURE DATE

MEDICARE AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO **DR. ARIF H. AGHA, M.D.,** FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF "OTHER HEALTH INSURANCE" IS INDICATED IN ITEM 9 OF THE HFCA-1500 FORM. OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASE OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NON-COVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

X_____ _____
SIGNATURE DATE

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PLEASE DESCRIBE THE REASON FOR YOUR VISIT TODAY:

_____

_____

WHAT PREVIOUS MAJOR MEDICAL EVENTS, HOSPITALIZATIONS, AND SURGERIES HAVE YOU HAD (WITH DATES)?

_____

_____

_____

MARK WITH AN "X" IF YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

____ DIABETES
____ HIGH BLOOD PRESSURE
____ CANCER
____ HEART CONDITION
____ ERECTILE DISFUNCTION
____ GASTROINTESTINAL CONDITION
____ EYE, EAR, NOSE, THROAT
____ SKIN
____ NEUROLOGIC
____ VASCULAR
____BLOOD IN URINE
____ LEAKAGE OF URINE
____ KIDNEY STONES
____ LUNG CONDITION
____Other

PLEASE EXPLAIN ANY CHECKED:

_____

_____

WHAT MEDICATIONS ARE YOU TAKING ON A REGULAR BASIS? PLEASE INCLUDE OVER-THE-COUNTER DRUGS SUCH AS ASPRIN, MOTRIN, AND VITAMINS (PLEASE USE ADDITIONAL PAGE IF REQUIRED):

NAME	FREQUENCY	DOSE	NAME	FREQUENCY	DOSE

LIST ALL ALLERGIES INCLUDING MEDICATIONS/SUBSTANCES (PLEASE USE ADDITIONAL PAGE IF REQUIRED):

NAME OF MEDICINE	TYPE OF REACTION	NAME OF MEDICINE	TYPE OF REACTION

DO YOU OR DID YOU EVER SMOKE: YES NO IF YES, HOW MANY PACKS PER DAY? ____ NO. OF YEARS: ____
ARE YOU EXPOSED TO SOMEONE ELSE'S SMOKING AT HOME OR AT WORK ON REGULAR BASIS YES NO

DO YOU HAVE ANY DISEASE(S) THAT RUN IN YOUR FAMILY?

____ PROSTATE CANCER ____ TESTICULAR CANCER ____KIDNEY CANCER ____OTHER:_____

FAMILY HISTORY (PLEASE LIST PRESENT STATE OF HEALTH OR CAUSE OF DEATH):

FATHER	ALIVE?	HEALTH	CAUSE OF DEATH	
MOTHER	ALIVE?	HEALTH	CAUSE OF DEATH	
BROTHERS	# ALIVE	HEALTH	# DECEASED	CAUSE OF DEATH
SISTERS	# ALIVE	HEALTH	# DECEASED	CAUSE OF DEATH
CHILDREN	# ALIVE	HEALTH	# DECEASED	CAUSE OF DEATH
SPOUSE	ALIVE?	HEALTH	CAUSE OF DEATH	

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Permissions, Consents, and Responsibilities

Consent to Treat: I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

Release of Information and Assignment of Benefits: I understand that I am responsible for any fees for service rendered for myself and/or for my children (if applicable). I hereby authorize Arif Agha, MD/Vasectomy Specialist Clinics of Chicago to release any medical information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse or mental illness in order to process any claims on my behalf. I hereby assign to Arif Agha, MD/Vasectomy Specialist Clinics of Chicago payments made by my insurance carrier.

Authorization to Discuss My Account: I hereby authorize the staff of Arif Agha, MD/Vasectomy Specialist Clinics of Chicago to discuss appointment information, test results and financial information with the following named person:

_____

Commitment to Your Care: I understand that in order to have an effective doctor-patient relationship it is my responsibility to be compliant with the physician's treatment recommendations and office policies. I understand that I may terminate this relationship at any time and request my records to transfer my care to another urologist. I further understand that the Vasectomy Specialist Clinics of Chicago' physicians may terminate the doctor-patient relationship at any time by giving 30-day written notice.

Continuity of Care:
I agree to keep my appointments for continuity of my medical care. If I do not cancel my scheduled appointment 24hours prior to the time of visit, I agree to pay $50 or applicable no show fee.

Privacy Notice: I hereby give my consent to Arif Agha, MD/Vasectomy Specialist Clinics of Chicago to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my patient record. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. I acknowledge that I have received the Arif Agha, MD/Vasectomy Specialist Clinics of Chicago Notice of Privacy Practices brochure or have received it on a prior visit.

_____ _____ _____

Signature Name Date