Fort Bend Urology

Henry T. Pham, M.D. Adult & Pediatric Urology

16659 SW Freeway, Suite 141 Sugar Land, Tex Phone: (281)494-8333 Fax: (281)494-8334

New Patient Checklist

- ❑ Please fill out the New Patient Demographic and Patient History forms.
  (If possible, please fax the completed packet to (281) 494-8334 before your appointment)
- ❑ Please bring your Picture ID or Drivers License
- ❑ Please bring all of your insurance cards and referral forms required by your insurance company
- ❑ Please bring a list of ALL the medications you are currently taking
- ❑ Please bring medical records for the reason of your visit. This includes films from recent X-Rays, imaging studies, and recent lab work done.)
- ❑ Male Patients- Please fill out an AUA symptom score sheet
- ❑ Please be ready to produce a urine specimen in the office

Location

We are located in Medical Office Building 2 of the Methodist Sugar Land Hospital. This is at the corner of Highway 59 and Sweetwater Blvd.
Our address is 16659 SW Freeway, Suite 141 Sugar Land, Texas 77479.
Our phone number is (281) 494-8333.

Payment

Payment is due at the time of service. This includes any copay, coinsurance, or deductibles. **For payment we accept Visa, Master Card, Cash.**
Please note that we do not accept Check, American Express or Discover cards.
If you would like to know what your responsibility would be for your visit, please call the office and ask for assistance.

We look forward to seeing you in the office!

Welcome ! Henry T. Pham, M.D.

Name: (First) ______________________________ (MI) ________ (Last) ___________________________________

DOB:________________ Sex: ☐ M ☐ F Marital Status: ☐S ☐ M ☐ D ☐ W SS#: ___________________

Address: (Street) ________________________________City: __________________ State: ______Zip : ___________

Home Tel #: ________________________Work #: ________________________ Cell #: _____________________

How may we contact you regarding appointments or results? ☐ Home ☐ Work ☐ Cell

May we leave messages on your voice mail? ☐Yes ☐ No Email Address: __________________________________

Preferred Language: _______________________ Ethnicity: ☐ Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture/origin) ☐ Non Hispanic or Latino

Race: ☐ White ☐BlackAfrican American ☐American Indian/Alaska Native ☐Pacific Islander ☐ Asian ☐ Other

Emergency Contact: ____ Relationship: _______________________

Home Tel #: ____________________ Work #: ________________________Cell #: _________________________

Employer : __________________Who referred you to our office? ☐ Doctor: _________________ ☐ Other: _______

Pharmacy Name: _________________________ Pharmacy Phone: (_____) _________________________

PRIMARY INSURANCE: ____________________________________ Phone # ___________________________

Policy Holder: _____________________________ ID #: _________________ Group #: _____________________

Relation to Patient: ________________________________ Date of Birth: __________________________________

SECONDARY INSURANCE: _______________________________ Phone # ____________________________

Policy Holder: _______________________________ ID: ________________________ Group #: _______________

Relation to Patient: _______________________________ Date of Birth: ___________________________________

Method of Payment: ☐ Visa ☐ MasterCard ☐ Discover ☐ Cash **(NO CHECKS/AMEX ACCEPTED)**

Release of Information: Health information Henry T. Pham, M.D. collects or receives about you may be disclosed to the following:

Name: ____ Relationship: ___________________________

Name: ____ Relationship: ___________________________

I have reviewed the Notice of Privacy Policies and Practices. I authorize the person(s) listed above to receive all health information about appointments, treatments and/or other information pertinent to my healthcare provided by Henry T. Pham, M.D. I authorize the release of any medical information needed to determine my medical reimbursement benefits under my insurance policy. This includes authorization to obtain medical information from the insurance carrier and pharmacy. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. The insurance may deny coverage for infertility, sexual dysfunction, and pre-existing medical condition. The office has no way of knowing all the terms of the policy.

Patient's Signature: ____ **Date:** ________________

Important

There will be a charge of $50 for missed appointments. We ask that you kindly give 24-hour notice to cancel or reschedule an appointment. _____________ **Initials**

We reserve the right to charge patients a $25 prescription reprinting fee for "lost" or "misplaced" prescriptions or for a request for prescription outside of an office visit. _____________ **Initials**

Our office may be able to pull your prescription, lab and claim history from your insurance carrier. I authorize this office to review my prescription, lab, and medical history if available electronically. _________ **Initials**

Dr. Henry Pham is pleased to offer you the opportunity to communicate with him via e-mail. There is no guarantee that e-mail messages will be secure once they are sent. This practice will not release confidential information about you without your written consent. ☐ I CONSENT ☐ **I REFUSE** I understand that e-mail messages I send will not be answered. _________ **Initials**

Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance we are committed to help you receive the maximum allowable benefits. **In order to achieve these goals we need your assistance and your understanding of our payment policy.**

Payment for all office services and supplies is due at the time service is rendered. This includes any copay, deductible or co-insurance determined by your insurance company.

We accept cash, MasterCard, Discover and Visa only. We **DO NOT** accept any checks, unless approved in advance through the Business Office. (Returned checks are subject to an additional fee of $50.00 and will terminate your privilege to pay by check).

We are happy to process your insurance form for reimbursement, but must be provided with appropriate proof of insurance and identification. This is a courtesy we extend to you, but ultimately payment for all charges for care provided is your responsibility.

Please inform us of any changes in your insurance policy. If such information is not provided, you will be responsible for the charges associated with your visit.

Surgical procedures may require a deposit, including deductible and or co-pay. Remaining balances are to be paid within one month of settlement with your insurance company. We pre-approve the surgical procedure with individual insurance carriers to determine benefits, but it is ultimately the patient's responsibility to pre-approve all surgical procedures and to be aware of conditions of approval, such as obtaining 2nd opinion, etc.

Important- Some insurance plans require patients to obtain referrals and/or preauthorization for services provided with a Specialist (i.e. Urologist). Ultimately it is the patient's responsibility to obtain the necessary referral or preauthorization from their Primary Care Physician (PCP). If we are not notified and subsequently unable to obtain preauthorization, you will be responsible for the bill.

We emphasize that as a medical care provider, our relationship is with you and not your insurance company. We cannot be responsible for any loss of benefits. It is your responsibility to know your policy. If you have any questions concerning the above information, please do not hesitate to ask us. We are here to help you.

By signing below I acknowledge that I have read and agree with the policy listed above.

____

Signature of Patient or Guarantor **Date**

Henry T. Pham, M.D. PATIENT MEDICAL HISTORY Date:________________________

Last Name:______________________________ First:__________________________ Date of Birth:_______________

Reason for your visit today: ____

MEDICATIONS LIST : ☐ None

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ALLERGIES: ☐ No known drug allergies

☐ IV contrast ☐ Levaquin ☐ Ciprofloxacin

☐ Aspirin ☐ Codeine ☐ Penicillin

☐ Iodine ☐ Sulfa Drugs ☐ Demerol

☐ Morphine ☐ Latex ☐other______________

FOR FEMALES: Are you currently pregnant? : ☐ YES ☐ NO Date last menstrual period began: __________________

FOR MALES: Are you currently taking ☐ Viagra ☐ Levitra ☐ Cialis

PAST UROLOGICAL HISTORY: ☐None ☐ Difficulty starting urination ☐ Difficulty stopping urination

☐ Bed wetting ☐ Blood in urine ☐ Frequent urination ☐ Kidney stones ☐ Pain in testis

☐ Prostate trouble ☐ Urgent urination ☐ Bladder Infections ☐ Burning urination ☐ Kidney infections

☐ Leaking urine ☐ Painful urination ☐ Swelling of testicles ☐ Urinating at night ☐ Venereal disease

☐ Bladder Cancer ☐ Kidney Cancer ☐ Prostate Cancer ☐ Urine infections ☐ Incontinence

☐ Problems with sexual function

PAST MEDICAL HISTORY: ☐ None ☐ Diabetes ☐ High blood pressure ☐ High Cholesterol

☐ Asthma ☐ Lung Disorder ☐ Heart attack ☐ Hemorrhoids ☐Stroke ☐ Bleeding Disorder

☐ Glaucoma ☐ Gout ☐ Hepatitis ☐ Depression ☐ Seizures ☐ Thyroid Disorder

☐ Liver disease ☐ Other: ____

FAMILY HISTORY: ☐ Cancer (Type:__________________) ☐ Diabetes ☐Heart disease ☐ Kidney disease

PREVIOUS SURGERIES: ____

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SOCIAL HISTORY:

Are you a smoker? ☐ Yes ☐ No ☐ Secondary smoking exposure

If you are a smoker, please check off: ☐ 1/4 pack/day ☐1/3 pack/day ☐1/2 pack/day ☐3/4 pack/day

☐ 1 pack/day ☐ 1.25 pack/day ☐1.5 pack/day ☐ less than ¼ pack/day ☐ occasionally ☐ Former smoker

☐ Social smoker Smoking onset date: __________________ ☐ Quit date ____________________

Do you drink alcohol? ☐Yes ☐ No

If you drink, please check off: ☐ Rare ☐ Socially ☐ Occasionally ☐Former drinker ☐ Alcohol dependency

☐ Recovering alcoholic

Exercise history: ☐ Walking ☐ Running ☐ Cardio ☐ Weights ☐ Aerobic ☐ Cycling ☐ Swimming

☐ Hiking ☐Yoga ☐Active lifestyle, but no organized exercise ☐ No exercise

Nutrition history: ☐ Poor diet ☐ Average diet ☐Good diet ☐ Excellent diet ☐ Vegetarian

Occupation history: ☐ Retired ☐ Unemployed ☐ Student ☐ Full-time ☐ Part-time ☐ Homemaker

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VASECTOMY INFORMATION

Before The Procedure:

- Stop taking all aspirin or blood thinning medications, NSAIDS(for example: ibuprofen, Aleve, Motrin, naproxen) one week prior to your vasectomy
- Clip excessively long hair from scrotum 1-2 days before, being careful not to nick the skin. Shaving the area is not required.

The Day of the Vasectomy:

- Wear or bring close-fitting underwear that will support the scrotum like briefs or boxer briefs, *NO BOXERS.*
- Have a *light* meal two hours before the procedure. Do not eat or drink for two hours before the procedure.
- Be sure to have someone drive you home from the procedure if you require a sedative for the procedure.

Post-Vasectomy Instructions:

- Wear close-fitting underwear for 2-3 days to hold the bandages in place
- Place an icepack on your scrotum to minimize swelling during the first 8 hours, (15 minutes on/15 minutes off).
- You may shower immediately but do not scrub the surgical site for the first week. After showering, apply the ointment we have provided for you to prevent infection.
- Avoid submerging your body under water for the first week (pool, spa, tubs).
- Expect to have testicular discomfort and groin discomfort, which may last as long as three weeks (sometimes even longer).
- Expect to have mild bruising around the area of the surgery.
- It is normal for you to be able to feel a “knot” over each testicle. The size of each knot should be no more than ¼ of an inch in size (this is normal inflammation after the procedure).
- Call if you note the following: fever over 101.5 F, excessive swelling of the scrotum with rapid increase in size, excessive amount of pain, or large amount of bleeding from the surgical site.
- You may resume normal activities 24 hours after the procedure if you do not have excessive pain, swelling, or bleeding from the site.
- You must continue to use contraceptive measures until we are able to confirm that you are sterile with a semen analysis (usually after four months).