# LAKEVIEW CENTER FOR UROLOGY

## Patient Registration Information

**Date:** _____

Please PRINT and complete ALL sections below

**Patient:** _____ **Social Security:** _____

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Sex: ____M ____F Age:____ Birth date:_____ Marital Status: S M D W

Patient employed by: _____ Work Phone: _____

Employer address: _____ Occupation: _____

**Responsible Party Information (if different from above)**

Responsible Party Name: _____ Social Security: _____

Birth date: _____ Address: _____

Relationship to patient: _____Spouse _____Parent _____Guardian _____Other

Address _____

Home Phone_____ Employed By _____

Work Phone _____ Occupation_____

Employer Address_____

**In Case Of Emergency Notify** _____ Phone _____

Relationship To Patient _____Spouse _____Parent _____Guardian _____Other

Personal or Referring Physician _____

Address_____ Phone _____

**Please Read And Sign The Following:**

I directly assign all medical/surgical benefits to Fawad S. Zafar, M.D. and understand that I am financially responsible for all charges whether or not paid by insurance. I understand that payment is due within 30 days of receiving an invoice. I further understand that Lakeview Center for Urology will not check my insurance benefits unless I have requested so prior to any appointments.

I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:_____ Date:_____

# Acknowledgement of Notice of Privacy

**Lakeview Center for Urology**
**Dr. Fawad Zafar**
**6000 University Avenue, Suite 250**
**West Des Moines, IA 50266**

Name of Patient: _____ Date of Birth: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

My signature below indicates that I have been given an opportunity to read this practice's Notice of Privacy Practices and to have any questions answered before signing.

Signed: _____ Date: _____

Print Name: _____

Telephone: _____

If not signed by the patient, please indicate Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Personal Representative of patient unable to sign

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***For Office Use Only:***

☐ Form received by: _____ Date: _____
Employee Signature

☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reason Patient Refused to sign:

_____

_____

# Medical Information/HIPAA Release Form

## Lakeview Center for Urology
## Fawad Zafar, M.D.

Name:_____ Date of Birth:_____

***Release of Information***

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____Spouse_____

_____Children_____

_____Other_____

_____Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

***Messages***

Please call _____my home _____my work _____my cell

Number:

If unable to reach me:

_____you may leave a detailed message

_____please leave a message asking me to return your call

_____ _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

# Outside Services for Radiology/Lab

Lakeview Center for Urology
Fawad Zafar, M.D.

This office uses outside services for radiology and some laboratory testing.

These outside services will be billed and filed to your insurance by the respective offices where the services are provided.

PLEASE NOTE: This office most frequently uses the Iowa Pathology Laboratory and Quest for lab work and Iowa Radiology for radiology testing.

If your insurance requires a specific facility for lab work or for x-rays you must notify this office beforehand.

All patients are responsible for co-pays or any amount applied to a deductible.

Thank you,

Lakeview Center for Urology

_____ _____

Patient Signature Date

**Lakeview Center for Urology**
**Fawad S. Zafar, M.D.**

| Patient Name | DOB | Ht. | Wt. |
|---|---|---|---|

| Referring Physician | Reason for Visit | Today's Date |
|---|---|---|

| PCP | Pharmacy | Race/Ethnicity | Language |
|---|---|---|---|

***Your Medical History*** None_____ Circle if yes:

| | | | |
|---|---|---|---|
| **Cardiac** | | | |
| Heart Valve | High Cholesterol | Heart Attack | Atrial Fibrillation |
| Congestive Heart Failure | Rheumatic Fever | Heart Stents | Defibrillator |
| Pacemaker | High Blood Pressure | | |
| **Respiratory** | | | |
| Asthma | Clots in Lungs | Sleep Apnea | COPD |
| Emphysema | | | |
| **Digestive** | | | |
| Irritable bowel syndrome | Ulcerative colitis | GERD | Peptic Ulcers |
| Diverticulitis | | | |
| **Endocrine/Eyes** | | | |
| Diabetes Type 1 | Diabetes Type 2 | Hypothyroid | Hyperthyroid |
| Open angled glaucoma | Closed angled glaucoma | | |
| **Blood/Immune** | | | |
| Cirrhosis | Leukemia | Lymphoma | Cirrhosis |
| Rheumatoid Arthritis | Lupus | Scleroderma | Clots in legs (DVT) |
| **Musculoskeletal** | | | |
| Total Joint Replacement | Osteoporosis | Fibromyalgia | Osteoarthritis |
| **Neurologic** | | | |
| Stroke | Spina Bifida | Depression | Seizures |
| MS | Parkinsons | Alzheimer's | |
| **Infectious Disease** | | | |
| AIDS | HIV | Hepatitis | MRSA, History of |

Any Cancer(s)_____
Any Radiation: No_____Yes____ Site on body_____

***Allergies*** None Circle if yes:

| | | | | | | |
|---|---|---|---|---|---|---|
| Penicillin | Ampicillin | Sulfa | Bactrim | Macrodantin | Levaquin | Cipro |
| Iodine | Tape | Latex | | | | |

Other:_____

***Medications***

| *Name of Medication* | *Strength* | *When you take* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you take antibiotics prior to procedures? YES___NO
If yes, what is the name of the antibiotic? _____

***Surgeries*** Type of surgery and approximate date:

_____

_____

***Genitourinary History*** None___ Please circle if yes:

| | | |
|---|---|---|
| Kidney Cancer | Kidney Stones | Prostate Infections |
| Prostate Cancer | Ureter Stones | Prostate Enlargement |
| Bladder Cancer | Bladder Stones | Infertility |
| Testicular Cancer | Bladder Infections | Kidney Failure |

Do you leak urine when you cough or exercise?_____
Do you leak urine when you feel and urge to urinate but cannot get to the bathroom in time?_____
Do you have problems achieving or maintaining an erection?_____

| ***Family Medical History*** | | ***Relationship to You*** |
|---|---|---|
| Cancer-Kidney/Bladder/Prostate | _____yes____no | _____ |
| Kidney problems/stones | _____yes____no | _____ |
| Blood pressure problems | _____yes____no | _____ |
| Bleeding problems | _____yes____no | _____ |
| Diabetes | _____yes____no | _____ |
| Asthma/Breathing problems | _____yes____no | _____ |
| Reaction to anesthesia | _____yes____no | _____ |
| Cardiac problems | _____yes____no | _____ |
| Parent's current age if alive: | Mother_____ | Father_____ |
| If deceased, age & cause of death: | Mother_____ | Father_____ |

***Social History***

Do you use tobacco? yes____no____ If yes, packs per day?_____
Have stopped using tobacco? yes____no____If yes, how long did you smoke? _____
What year did you quit? _____
Do you use alcohol? yes____no____ If yes, how often and how much? _____
Do you use caffeine? yes____no____ If yes, how often and how much? _____
Do you use recreational drugs? yes____no____If yes, what kind? _____
# of children _____ # of pregnancies _____ Currently pregnant _____yes____no____

***Have you ever had a Blood Transfusion? Yes___ No___***