

Black Hills Urology Group

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PLEASE FILL THIS FORM OUT COMPLETELY

Patient Name: _____ Date of Birth: _____ Date: _____
Mailing Address: _____ City: _____ Zip Code: _____ State: _____
Home Phone Number: _____ Cell Phone Number: _____
Social Security No: _____ Insurance: _____ Marital Status: (M / S / D / W)
Primary Care Physician: _____ Referring Physician: _____
Height: _____ Weight: _____ Occupation: _____ Employer Name: _____

1. Reason For Visit: _____
2. Drug Allergies: _____
3. List of Current Medications: _____
4. Previous Surgeries (Please Include Approximate Dates) _____

5. Previous Hospitalizations, Other Than Surgery (Please Include Approximate Dates) _____

6. Do You Smoke? YES/NO If Yes, how much? _____
7. Do You Drink? YES/NO If Yes, how much? _____
8. List Any Illnesses That Run In Immediate Family (If Cancer; please specify what type): _____

9. If You Are Female, Date Of Last Menstrual Period: _____
9a. Are You Pregnant? YES / NO

10. Do You Have A History Of Any Other Illnesses (e.g. arthritis, gout, glaucoma, hypertension, diabetes mellitus, heart disease, etc.)? If So, Please List. _____

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. *You are responsible for all deductibles and charges not covered by insurance.* Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. Therefore; by signing below, I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf; however, if my insurance company or other pre-arranged payor denies payment for any reason (e.g. non-covered services, or services deemed by my insurance company routine/preventative medical visits, or my failure to secure a referral from my primary care physician if required by my insurance company), I will pay for these services upon written/verbal notice of their refusal. If a denial or refusal to pay is received I understand I will be responsible to pay the full amount within 45 days, otherwise this will be considered a refusal to pay. In the event I do not pay for these or any other services provided me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a law suit is commenced as part of the collection process.

(Patient / Parent / Legal Guardian) Signature: _____ Date: _____