RONALD W. ROSENQUIST, M.D.

Health History

HEALTH HISTORY:

Name: ________________
Date: ________________
Age: ________________

UROLOGIC PROBLEM:
What is the problem or symptom that brought you here?

____
____
____

PAST HISTORY:
Surgery: List all operations (tonsillectomy, appendectomy, etc.) you Have had and approximate date:

____
____
____
____

Major Illnesses: ____
____
____

Do you smoke? ___ What ?______________How often? ________________
Have you ever smoked? _____How long?____When did you quit?_____
Do you drink alcohol? ___ What? _________How often? _____________

RONALD W. ROSENQUIST, M.D.

Patient Information

NAME: ____
Last **First** **M.I.**

ADDRESS: ____
Street

____
City **State** **Zip**

PHONE: ____________________ **CELL:** ____________________

e-mail: ____________________________ **Date of Birth:**______________ **Sex:** ________

Social Security #: ***(required)***________________________ ******This information is strictly***

Driver's License:*(required)*________________________ ***confidential.***

Occupation: ______________________ **Employer:** ______________________________
(or former occupation, if retired)

Address: ____________________________
____________________________ **Work phone:** __________________

Spouse's name: ____________________

Referred by: __________________ **Family or Primary Care Dr.:**______________

INSURANCE INFORMATION

***Do you have Medicare? Yes / No If Yes ID#**______________________________
Insurance Company: ____
Subscriber Name:______________________________
Subscriber Date of Birth:________________________
Subscriber I.D.:________________________________
Subscriber Employer ____________________________
Group # : ____________________________________

PLEASE SIGN AND RETURN TO RECEPTIONIST

I hereby give consent for medical information to be sent to my Referring &/or Primary Care Physician.

I also request that payment of authorized insurance benefits be made on my behalf to Ronald W. Rosenquist, M.D. for any service furnished me by Dr. Rosenquist. I authorize any holder of medical information about me to release such information necessary to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I understand that if I am found to be ineligible for insurance coverage, I am responsible for all costs incurred in the delivery of medical services to me and will pay these charges within 30 days of billing. Co-payments will be collected at the time of service. There will be a $25.00 fee on each returned check.

Signature: ____________________________________ **Date:** __________________