

**Dennis L. Ortiz, D.O.**  
**Patient Information (Female)**

(please print clearly)

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX (Circle One): Male / Female

Circle One: Single / Married / Divorced / Widowed / Separated

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address/City/St/Zip: \_\_\_\_\_

Spouse or Parent Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Work Address/City/St/Zip: \_\_\_\_\_

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Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

ID/Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance address (Complete): \_\_\_\_\_

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Please give name, address and phone # of PCP and/or physician who referred you to Dr. Ortiz:

\_\_\_\_\_

Name, address, phone number and relationship of nearest relative or friend, preferably not living with you, who can be reached in case of emergency:

\_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_ **Location:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_

**PLEASE SEE REVERSE SIDE FOR ADDITIONAL INFORMATION.**

**PLEASE READ THE INFORMATION BELOW CAREFULLY**

**The patient is responsible for deductible, co-insurance, co-payments and non-covered services as determined by their Insurance Carrier. We will file for secondary coverage, however, we must be provided with this information.**

Patients who carry health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. For insurance companies with which Dr. Ortiz has a contract, the stated co-payments are expected at the time services are rendered, as are calculated coinsurance percentages.

Even though an insurance claim is filed on your behalf, this office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. As the beneficiary, you are responsible for payment of your account within the limits of our credit policy. You will receive a statement once the insurance payment or denial has been received.

It is the responsibility of the insured to keep this office informed of any insurance or primary care physician changes prior to appointments and to ensure that this office has received necessary referrals for specialist care.

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**PLEASE READ CAREFULLY AND SIGN WHERE APPROPRIATE**

For all services provided by Dr. Dennis Ortiz, I hereby assign all medical/surgical benefits, to include major medical benefits, to Dr. Dennis Ortiz. I give permission to Dr. Ortiz to examine and administer such treatment as may be necessary or advisable, based on my diagnosis. I have the right to refuse recommended treatment. I authorize Dr. Ortiz to bill my insurance for services rendered and to provide the insurance company with the necessary information needed in order to properly process and provide payment for my claim. I understand that I am financially responsible for all charges, whether paid or not by my insurance, within the limits of existing contracts with specific carriers. A photocopy of this authorization shall be considered as valid as the original. This authorization can be revoked in writing for any future services provided.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

For Medicare claims, I authorize any holder of medical or other information about me to be released to the Social Security Administration and to CMS or its intermediaries or carriers all necessary information needed in order to properly process and provide payment for my claim. I give permission to Dr. Ortiz to examine and administer such treatment as may be necessary or advisable, based on my diagnosis. I have the right to refuse recommended treatment. I understand that I am financially responsible for non-covered charges and all applicable deductibles and copayment amounts. A photocopy of this authorization shall be considered as valid as the original. This authorization can be revoked in writing for any future services provided.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

I give permission to Dr. Ortiz to examine and administer such treatment as may be necessary or advisable, based on my diagnosis. I agree to abide by any financial arrangements made at the time of service. If at some time in the future I become eligible for insurance coverage, I authorize the release of all necessary information to establish eligibility and determine benefits available. I have the right to refuse recommended treatment. This authorization can be revoked in writing for any future services provided.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Office Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

***North Central Urology P.A.***  
**ADULT AND PEDIATRIC UROLOGY, BOARD CERTIFIED**  
**4218 Gateway Dr., Suite 100, Colleyville, TX 76034**  
(817) 283-1860 FAX (817) 283-2175  
Answered 24 hours/after hours emergency only  
OFFICE POLICY

The following information is presented to assist you in understanding the administration of our office policy.

**APPOINTMENTS:**

Our office is open Monday through Thursday from 8:30am to 5:30pm, Friday 8:00am to 5:00pm We are out of the office for lunch from 12:00n to 1:00pm

All scheduling of appointments, rescheduling and cancellations must be made through the office during these hours, at extension 202.

A 24 hour advance notice is required for any changes to the schedule.

**CHARGES:**

Payment is required at the time that services are rendered; if you are not prepared to pay, the appointment will be rescheduled.

WE ACCEPT CASH, CHECK, VISA, AND MASTER CARD ONLY.

There will be a charge for all written forms, reports, or letters which require preparation time, research (professional or medical), or professional or medical decision-making. There will be a charge for release of medical records to anyone other than another physician. A signed medical records release form must be completed.

All patients (Medicare, PPO, HMO, Indemnity) are responsible for their balance after insurance has been filed.

All patients are responsible for updating our office with any changes in responsible party, billing, or insurance information. Patients with Medicare must inform our office of any changes to Medicare carrier, (i.e.: SecureHorizons, PacifiCare, etc.) PRIOR TO any office visit, procedure, or treatment so that a correct and valid referral is on hand, if required.

**Disclosure of Physician Ownership**

Baylor Medical Center at Trophy Club, Baylor Surgicare at Bedford and I are committed to providing clinical excellence in a safe, comfortable environment for you and your family members. I am a percentage owner of both facilities. This ownership enables me to have a voice in the administration and policies of both facilities. This involvement helps to ensure the highest quality of care for you.

Baylor Medical Center at Trophy Club and Baylor Surgicare at Bedford both meet the Federal definition of a physician-owned facility and a list of each facility's owners that are physicians (or their immediate family members) is available from either facility upon your request.

If you have any questions concerning this notice, please feel free to ask Dr. Dennis Ortiz or the Chief Executive Officer at either Baylor Medical Center at Trophy or Baylor Surgicare at Bedford. We welcome you as a patient and value our relationship with you.

I have received a copy of this notice:

\_\_\_\_\_  
Patient or responsible party

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

# PATIENT HISTORY FORM

**Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.**

Today's Date \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

Patient Name \_\_\_\_\_ SS # : \_\_\_\_\_ DOB: \_\_\_\_\_

## CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

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## History of Present Illness

Please answer the following questions.

Location of the problem

Abdomen      Back      Leg  
Other \_\_\_\_\_

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How long does the problem last?

30 minutes      1 hour      It's always there  
Other \_\_\_\_\_

On a scale of 1-10, with 10 being the most severe, circle one number that best describes the problem

1 2 3 4 5 6 7 8 9 10

Is anything else occurring at the same time?

Yes    No    If yes, please explain.  
Nausea    Rash    Headaches  
Other \_\_\_\_\_

When did you first notice the problem?

2 days ago      2 weeks ago      1 month ago  
Other \_\_\_\_\_

Is the problem constant or variable?

Dull then sharp    Very sharp then leaves    Always there  
Other \_\_\_\_\_

Does anything help or make the problem worse?

Moving around    Standing up    Lying on my side  
Other \_\_\_\_\_

Does the problem interfere with your normal functions?

Yes    No    If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

## Physician use only: (Comments/Notes)

# Answer	Level of Service
1-3	1 or 2
4+	3 - 5

## Past Medical and Social History

List all serious illnesses in your immediate family. (example: diabetes, tuberculosis, cancer of chest, cardiac disease, etc.)

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List any personal past illnesses and or surgeries and when they occurred.

Illness or Surgery	Date
_____	_____
_____	_____

Are you on any medications:    Y    N    (please list)

\_\_\_\_\_

Are you on a special diet?    Y    N    (explain)

\_\_\_\_\_

Do you smoke?    Y    N  
If yes, how much? \_\_\_\_\_

Do you have allergies?    Y    N    (please explain)

\_\_\_\_\_

Do you drink?    Y    N  
If yes, how much \_\_\_\_\_

## Physician use only: (Comments/Notes)

#Answer	Level of Service
0	1 or 2
1-2	3
3	4 or 5

**BLADDER SATISFACTION SURVEY**

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Doctor \_\_\_\_\_

**Which symptoms best describe you? (Circle All That Apply)**

- Frequent Urination – Day, Night, or Both
- Sudden or Strong Urge to urinate
- Unable to empty the Bladder
- Leaking with Sneezing, Coughing, Exercising
- Leaking with Urge or No Warning (Unable to make it to the bathroom in time)
- Bladder or Pelvic Pain

**How long have you had these symptoms?** \_\_\_\_\_

**Have you tried medications to help your symptoms?**  Yes  No

**If yes, circle the medications you have tried:**

- Detrol® LA
- Ditropan XL®
- Flomax®
- Cardura®
- Gelnique®
- Oxytrol® Patch
- Enablex®
- VESIcare®
- DDAVP®
- Toviaz®
- Sanctura®
- Elavil®
- Elmiron®
- Other \_\_\_\_\_

**Did these medications help your symptoms? Circle #**

0	1	2	3	4	5	6	7	8	9	10
<b>No Relief</b>					<b>Completely Cured</b>					

**If you’ve stopped taking your meds explain why: (Circle All That Apply)**

- Did not Help
- Side Effects
- Too Expensive

**Describe Side Effects** \_\_\_\_\_

**Behavior Modifications Tried** \_\_\_\_\_  
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

**What is your level of frustration with your bladder symptoms? Circle #**

0	1	2	3	4	5	6	7	8	9	10
<b>Not Frustrated</b>					<b>Very Frustrated</b>					

**Do you currently have any problems with bowel function? (Circle All That Apply)**

- Fecal Incontinence
- Constipation
- Other

**I am interested in learning more about treatment alternatives to medications:**

- Yes
- No