



Cowles Clinic Center for Urology

Robert S. Cowles III, M.D., F.A.C.S.

1000 Cowles Clinic Way
Cypress Cottage, Suite C-100
Greensboro, GA 30642
Tel: 706.454.0100 | Fax: 706.454.0101
www.atlantacenterforurology.com

PATIENT INFORMATION FORM

Today's Date: _____ Drug Allergies: _____
Patient Number: _____

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Date of Birth: _____

Race: (check one) White Black Hispanic Asian Native American Other Unknown

Sex: (check one) Male Female

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Pharmacy: _____ Pharmacy Number: _____

Next of Kin and Emergency Contact Information:

First Name: _____ Last Name: _____

Relationship: _____ (Check appropriate box) Next of Kin Contact

Home Phone: _____ Work Phone: _____

Referring Physician Information:

First Name: _____ Last Name: _____

Practice: _____ Specialty: _____

Email: _____ UPIN: _____

Physician Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Is this your Primary Care Physician? Yes No

If No, who is your Primary Care Physician? _____

Insurance Information:

Primary Payor: _____

Subscriber Name: _____ Subscriber Number: _____

Group Name: _____ Group Number: _____

Copay \$: _____ Effective Date: _____

Secondary Payor: _____

Secondary Subscriber Name: _____ Secondary Subscriber Number: _____

Secondary Group Name: _____ Secondary Group Number: _____

Copay \$: _____ Effective Date: _____

Past Medical History:

List of Medical Illnesses:

(Date)

Prior Surgeries and Hospitalizations:

Current Medications – Dose and Schedule:

Allergies and Reactions (Drug, Food or Other):

Family Medical History:

Family History of: (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease (C.A.D.) | <input type="checkbox"/> Hypercholesterolemia (elevated cholesterol) |
| <input type="checkbox"/> Hypertension (elevated bloodpressure) | | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Prostate Cancer | | <input type="checkbox"/> Stroke (C.V.A.) |

Other Family History: _____

Social History:

Tobacco Use: Non Smoker Former Smoker

Type: Cigarettes Cigars Pipe Tobacco Chew Snuff

_____ packs per Day Week Month

Years of use _____ Quit Date _____

Alcohol Use: Non Drinker Occasional Social Heavy

Drug Use: Non User Type: _____ use per Day Week Month

Other Social History: _____

Patient Name: _____

Review of Systems: (circle appropriate response)

● **Constitutional Symptoms:**

Weakness No Yes
Weight loss No Yes
Malaise No Yes
Other/details: _____

● **Integumentary (Breast/skin):**

Skin infections No Yes
Rash No Yes
Glaucoma No Yes
Other/details: _____

● **Eyes:**

Double vision No Yes
Blurry Vision No Yes
Other/details: _____

● **Ears, Nose, Mouth, Throat:**

Head:
Headaches No Yes
Congestion No Yes
Other/details: _____

Ear:

Dizziness No Yes
Other/details: _____

Nose:

Nasal congestion No Yes
Other/details: _____

Mouth/Throat:

Hoarseness No Yes
Other/details: _____

● **Cardiovascular:**

Swelling of feet, ankles or hands No Yes
Difficulty breathing on exertion No Yes
High blood pressure No Yes
Heart attack No Yes
Heart surgery No Yes
Shortness of breath No Yes
Racing heart beats No Yes
Chest pain at rest No Yes
Chest pain with exercise No Yes
Other/details: _____

● **Respiratory:**

Chronic or frequent cough No Yes
Difficulty breathing at rest No Yes
Other/details: _____

● **Gastrointestinal:**

Abdominal pain No Yes
Blood in stools No Yes
Constipation No Yes
Other/details: _____

● **Genitourinary:**

Frequent urination No Yes
Leakage or dribbling No Yes
Reduced flow No Yes
Blood in urine No Yes
Pelvic pain No Yes
Sexual difficulty No Yes
Other/details: _____

● **Musculoskeletal:**

Neck pain No Yes
Joint stiffness No Yes
Muscle weakness No Yes
Other/details: _____

● **Neurological:**

Confusion No Yes
Headache No Yes
Fainting No Yes
Other/details: _____

● **Psychiatric:**

Anxiety No Yes
Mood swings No Yes
Other/details: _____

● **Endocrine:**

Excessive thirst No Yes
Breast enlargement No Yes
Abnormal hair growth No Yes
Low level of activity/tired No Yes
Other/details: _____

● **Hematologic:**

Excessive bleeding with dental work No Yes
Bruising No Yes
Other/details: _____

● **Allergic/Immunologic:**

Sneezing No Yes
Itching of eyes or nose No Yes
Other/details: _____



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Payment Policy

You are responsible for paying your insurance deductible, if not already satisfied, and insurance co-payment upon completion of visit. Please be advised that filing with your insurance plan is a service that is provided by us for your convenience. Therefore, it is your responsibility, as a patient, to determine whether or not Dr. Cowles is a provider within your plan or is considered a provider "out of network". It is also your responsibility to insure that appropriate referral procedures are executed in accordance with the provisions of your particular plan. If Dr. Cowles is "out of network", you are responsible for any charges not covered by your insurance plan and must pay those charges within 10 days from the date of invoice.

Please note that after six weeks if your insurance company has not responded to the claim filed, you will be notified that the unpaid balance is payable in full and within 10 days of notification.

If your insurance company requires additional information about you that is unavailable to us, the balance on your bill is your responsibility until the information requested is provided.

Your signature below constitutes your agreement to the above stated policy.

Patient Printed Name: _____

Patient Signature: _____



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PATIENT NAME: _____

PATIENT'S AGENT OR REPRESENTATIVE: _____

MEDICARE ASSIGNMENT AND AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, or its intermediaries or carrier. Any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment and benefits apply.

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS TO PHYSICIAN

For value received, I hereby transfer, assign and set over to Robert S. Cowles III, M.D. or Atlanta Center For Urology all insurance benefits of every kind and description for basic and major medical coverage, which benefits would be payable directly to me but for this assignment, and not to exceed the physicians usual and customary charges for services rendered to me. I understand that I am responsible to the physician for all fees and charges not paid by my insurance.

Signature: _____ Date: _____

RELEASE OF INFORMATION

I authorize the release of any and all medical information necessary to complete my insurance claims.

Signature: _____ Date: _____

AUTHORIZATION FOR TREATMENT

I am suffering from a condition requiring medical care, do hereby voluntarily consent to medical care encompassing diagnostic procedures and medical treatment, including medical X-rays, drugs, labwork, etc., as may be ordered by physicians responsible for such medical care. I further consent to treatment by authorized employees or agents to the Atlanta Center For Urology who are assigned to my care.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments, examinations, medical, or hospital care at the Atlanta Center For Urology.

This form has been fully explained to me and I certify that I understand its contents.

Signature: _____ Date: _____



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American Urological Association Symptom Score Sheet

Name: _____

Date: _____

	Not at All	Less than 1 time in 5	Less than 1/2 the time	1/2 the Time	More than 1/2 the Time	Almost Always
OVER THE PAST MONTH OR SO...						
1. How often have you had a sensation of not emptying your bladder completely after you finished urinating?	[0]	[1]	[2]	[3]	[4]	[5]
2. How often have you had to urinate again less than 2 hours after you finished urinating?	[0]	[1]	[2]	[3]	[4]	[5]
3. How often have you stopped and started again several times during urination?	[0]	[1]	[2]	[3]	[4]	[5]
4. How often have you found it difficult to postpone urination?	[0]	[1]	[2]	[3]	[4]	[5]
5. How often have you had a weak urinary stream?	[0]	[1]	[2]	[3]	[4]	[5]
6. How often have you had to push or strain to begin urination?	[0]	[1]	[2]	[3]	[4]	[5]
7. How many times do you typically get up at night to urinate, from the time you went to bed until getting up?	[0]	[1]	[2]	[3]	[4]	[5]

Bother Score = Sum of Questions 1-7 _____

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about it?
(Circle choice)

[1] Delighted

[2] Pleased

[3] Mostly satisfied

[4] Mixed

[5] Mostly dissatisfied

[6] Unhappy

[7] Terrible



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Receipt of Notice of Privacy Practices **Written Acknowledgement Form**

I, _____ have received a copy of
Patient Name

ATLANTA CENTER FOR UROLOGY's Notice of Privacy Practices.

Signature of Patient

Date

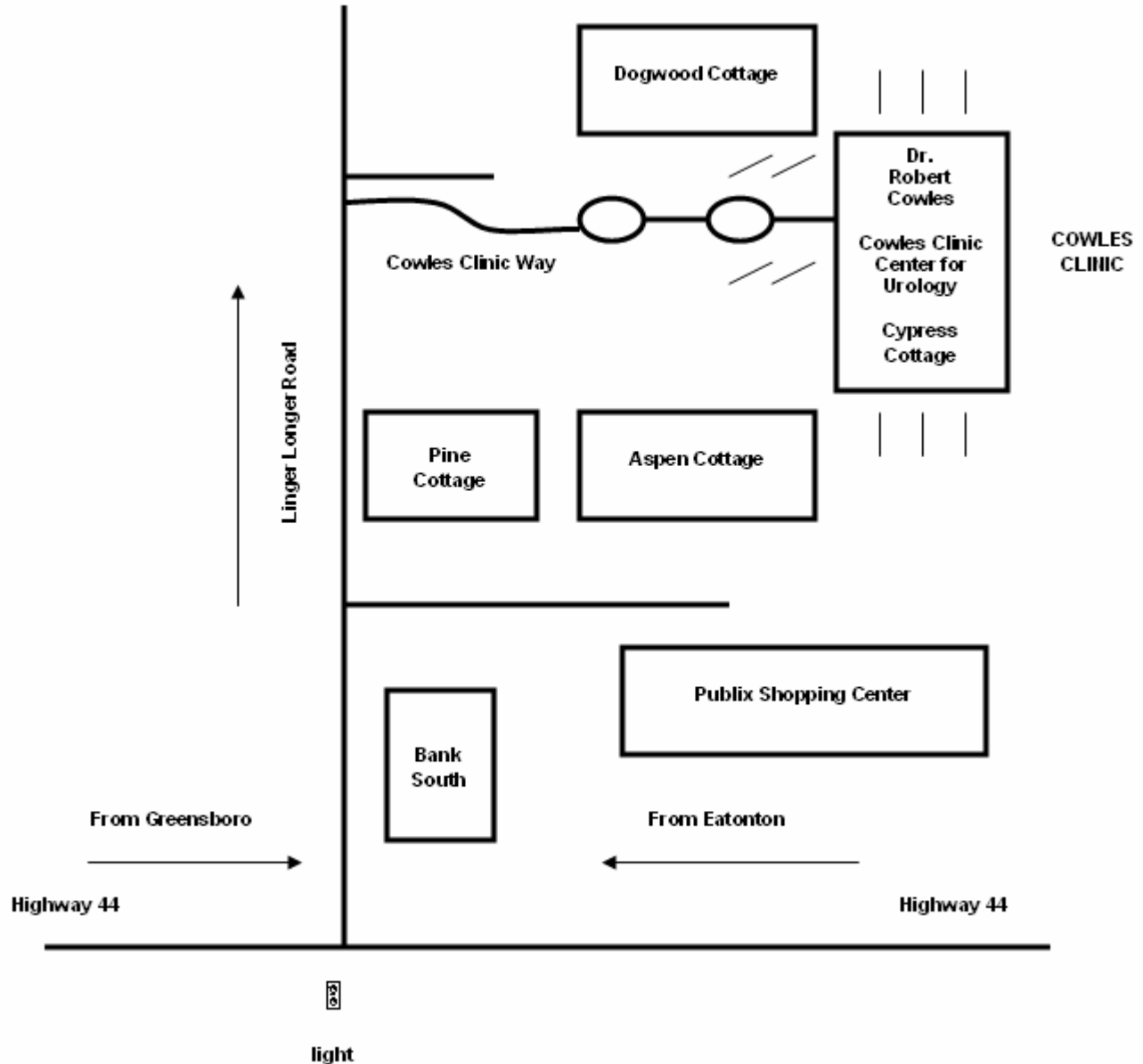


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From Greensboro: Go W on Hwy 44, turn L on Linger Longer Rd, go 1 mile, and turn R on Cowles Clinic Way.

From Eatonton: Go E on Hwy 44, turn R on Linger Longer Rd, go 1 mile, and turn R on Cowles Clinic Way.

Please call us if you need assistance with directions



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Directions to the Cowles Clinic from Greensboro:

At the Intersection of Interstate 20 and Highway 44 (Lake Oconee Parkway)

Go 8 miles on Highway 44 West

First Stoplight turn left on Linger Longer Road (towards the Ritz-Carlton)
Bank South is on the corner to your left

Go 1 mile on Linger Longer Road towards the Ritz-Carlton

Cowles Clinic is on the Right (you'll see 3 tall flag poles and 2 large fountains)

See the Reynolds Walk sign - turn Right

See the Cowles Clinic sign

Follow parking signs

Dr. Robert Cowles is in Cypress Cottage, second floor (use elevator please)

Directions to the Cowles Clinic from Eatonton:

Highway 44 (Lake Oconee Parkway) towards Greensboro

Go approximately 17 miles

Second Stoplight turn Right on Linger Longer Road (towards the Ritz-Carlton)
Bank South and Publix Supermarket are on your Right

Go 1 mile on Linger Longer Road towards the Ritz-Carlton

Cowles Clinic is on the Right (you'll see 3 tall flag poles and 2 large fountains)

See the Reynolds Walk sign - turn Right

See the Cowles Clinic sign

Follow parking signs

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