Urology With Dignity, P.A.

Joan T. Meaney, M.D., P.A.
7434 Louis Pasteur Dr. Ste. 215 San Antonio TX 78229
Phone: (210)463-9642 Fax: (855)783-1225
www.joanmeaneymd.com

ATTENTION NEW PATIENTS:

We are here to help you.

Please note: If you need to cancel or reschedule you must give our office at least a 24-hour notice as this can affect your ability to make another appointment.

A mask will be required to enter our office **even if you have been vaccinated.**

In order to help our clinic run smoothly and in a timely manner we ask that all new patient documents be filled out completely before coming in for your appointment. Failure to do so will delay your appointment and you will be placed at the end of clinic. Please have your ID and insurance card(s) readily available so that we may scan them into our system. If you have been vaccinated for COVID-19 we would like to scan in that documentation as well. If you have any other documents that you would like the doctor to review, please give them to the front desk so that we may scan them in and have them ready for Dr. Meaney to review. As a courtesy, please refrain from using your cell phone while you are in our office as this will also delay your appointment.

Please note we do have our waiting room closed and we are asking patients to call us once they have arrived from the parking lot, we will then give you a call once there is a room available.

We will be requesting a urine sample upon arrival as well as for every visit if you are waiting to be seen and need to urinate, please let a staff member know so that we may assist you and you can leave a sample.

Thank you for your understanding and cooperation.

Urology with Dignity PA

Name: ____ D.O.B. _____/_____/_____ Date: _____/_____/_____

Past Surgical History: Please Circle

Cardiovascular: Angioplasty   Heart Stents   Coronary Artery Bypass(CABG)   Carotid Artery
Pacemaker   Heart Valve Surgery   Congenital Heart Problem   Blood Thinners/ Aspirin

General/ GI: Hernia Repair (Site:____________)   Appendectomy   Gallbladder   Colon Surgery   Laminectomy

Gyn: Started Period(age): ______ Menopause(age):_____Pregnancies(#):_____ Vaginal(#)_____ C-Section(#):_____
Hysterectomy(age)____ Ovaries Removed(age):_______

GU: Bladder Suspension   Stent Stone Surgery   Lithotripsy (ESWL)   Urethral Stricture   Vasectomy
Testis Surgery/ Removal   Kidney Surgery/Removal   Prostate Biopsy   TURP   Prostate Removal

Orthopedic: Hip Surgery   Knee Replacement   Back Surgery   Shoulder Surgery

Please list any other surgeries and date:____

Social History: Please Circle

Marital Status: Married   Single   Separated   Divorced   Widow   Significant Other
Highest Education: High School   College   Vocational/ Trade   Graduate Degree   Doctorate Degree   Other
Job Status: Full Time   Part Time   Student   Retired   Other:______________________________
Alcohol Use: None   Yes________ drinks per   day   week   month   year
Tobacco Use: None   Former User Date quit____________ Tobacco packs per day______x______yrs.

Family History: Please Circle

Please indicate if Maternal (M) or Paternal (P)

Cancer (Type?):	Mother	Father	Sister	Brother	Grandmother (M / P)	Grandfather (M / P)
Heart Disease:	Mother	Father	Sister	Brother	Grandmother (M / P)	Grandfather (M / P)
High Blood Pressure:	Mother	Father	Sister	Brother	Grandmother (M / P)	Grandfather (M / P)
Stroke:	Mother	Father	Sister	Brother	Grandmother (M / P)	Grandfather (M / P)
Diabetes:	Mother	Father	Sister	Brother	Grandmother (M / P)	Grandfather (M / P)
Kidney Stones:	Mother	Father	Sister	Brother	Grandmother (M / P)	Grandfather (M / P)
Enlarged Prostate:	Mother	Father	Sister	Brother	Grandmother (M / P)	Grandfather (M / P)

Medical Symptoms: Please Circle

General: None   Chills   Fever   Hot Flashes   Weight Loss: _____lbs. Weight gain:_____lbs.
Eyes: None   Blurred Vision   Double Vision   Low sight/ blindness   Dry eyes   Glaucoma
Allergies: None   Seasonal____________ Foods______________________   Multiple Medications
Neurological: None   Dizziness   Headache   Confusion
GI: None   Constipation   Diarrhea   Bloating   Heartburn   Cramping   Colitis
Muscle & Joints: None   Arthritis   Joint Pain   Fatigue   Cramps
Respiratory: None   Shortness of Breath   Wheezing   Productive Cough   Pleurisy/ Pain
Heart: None   Chest Pain   Fatigue   Leg Edema   Palpitations   Fast Heart Rate
Hematological: None   Anemia   Swollen   Glands   Bleeding   Easy Bruising

---

Vaccines: Covid-19 Date ___/___/___ 2nd Date ___/___/___ Flu Date: ____/___/___ Pneumonia(65+yrs)Date: ___/___/___

Mammogram(55+yrs): Date: ___/___/___ Location: ________ Results: ______ **OR** Bilateral / Unilateral Mastectomy

Depression: Feeling down, depressed, or hopeless? **Yes/ No**   Little to no interest or pleasure in doing things? **Yes/No**

Name: ____DOB:______/______/______Date:______/______/______

Medications(Please PRINT Clearly) :(Name, Dose, and include over the counter meds)

1.____ 5.____

2.____ 6.____

3.____ 7.____

4.____ 8.____

Medication Allergies (reactions): ____
____

Past Medical History (Please Circle)

Cardiovascular: Atrial Fibrillation Congestive Heart Failure Edema/Swelling
Heart Attack (MI) Stroke Hypertension (High Blood Pressure) Deep Thrombosis (DVT)
Blood Clotting Problems Type:_______________________________________ Other:_______________________

Endocrine: Diabetes Gout Hyperthyroid Hypothyroid Adrenal Other:________________________

General: Hepatitis Renal/ Kidney Dialysis Elevated Cholesterol Other:______________________

GI: Inflammatory Bowel Dis.(IBS) Diverticulitis Crohn's Ulcerative Colitis Gluten Intolerance Other:____________

Urology(GU): Interstitial Cystitis Incontinence Bladder Infections(UTI) Kidney Stones
Overactive Bladder(OAB) Bladder Discomfort/ Pressure Blood In Urine(Hematuria)
Prostate Enlargement Urinary Retention Elevated PSA Erectile Problems Low Testosterone
Other **or** appointment reason: ____

HEENT: Sinus/ Seasonal Allergies Glaucoma Low Vision/ Blindness Cataracts Hard of Hearing Other:______

Rheumatology: Arthritis Fibromyalgia Sjogren's Syndrome Low Immune System Other: ________________

Neurological: Alzheimer's Bi-Polar Anxiety Depression Migraines Parkinson's
Multiple Sclerosis Spina Bifida Seizures Stroke TIA Other: ________________________________

Respiratory: Asthma COPD Emphysema Tuberculosis (TB) Pulmonary Embolism Other: _____________

Cancer: Breast R/L Colon Rectum Lung Cervical Uterus Ovary
Kidney R/L Bladder Prostate Testicular Other: _____________ Treatment: _________________________

Joan Meaney,M.D., P.A.

7434 Louis Pasteur Dr. Ste. 215 San Antonio TX 78229
Phone: (210)463-9642 Fax: (855)783-1225

Appointment Date/ Time		Resource	
Appointment Reason		Co-Pay	

Patient		Address	
Date of Birth			
Age		City	
Gender		State	
Referring Doctor		Zip Code	
Social Security Number		Marital Status	
Preferred Language		Home Phone	
Race		Work Phone	
Ethnicity		Cell Phone	
		E-Mail	
		Pref. Contact Method	

Primary Physician

Primary Care Physician		Address	
Office Phone			
Fax			

Primary Insurance		Secondary Insurance	
Member ID #		Member ID #	
Group #		Group #	
Insured's Name		Insured's Name	
Insured's DOB		Insured's DOB	
Insured's Gender		Insured's Gender	

Pharmacy Information and Emergency Contact Information

Preferred Pharmacy		Emergency Contact	
Address/ Intersection		Relationship	
City/ State/ Zip		Primary Number	
Phone #		Secondary Number	

I hereby authorize and Joan T. Meaney, M.D., P.A. to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign to the physician all payments for medical services rendered to me or my dependents. I understand that I am ultimately responsible for the balance of my account for any professional services rendered. Joan T. Meaney, M.D., P.A. may share information about you with other health care providers, third party payers or others through facsimile (FAX) communication devices. There is a small risk that confidential information may be accidentally transmitted to people not authorized to receive it. Your signature below authorizes us to use FAX communications at our discretion. If you do not wish any information concerning your medical condition, be transmitted by FAX, please notify us, please understand Fax communications expedite your care. Our office may leave messages on your answering machine. These messages may identify you as a patient of ours/ contain confidential information; your signature below authorizes us to use answering machines at our discretion. If you do not wish us to use answering machines, please notify us. Please note the use of answering machines expedite your care.

Sign: ____Date: ______/______/______

Joan T. Meaney, M.D., P.A

Patient Name: ____ DOB: ________________________

Physician/ Provider Joan T. Meaney, M.D., P.A.
I request and authorize medical treatment as may be deemed necessary and appropriate by the physician and her designees participating in my care. This care may include diagnostic, radiology and laboratory procedures, therapeutic procedures, drugs, nursing and hospital care.

My signature below indicates my acknowledgement that I have read and agreed to the above.

Patient/ Guardian Signature ____Date: ________________

CONSENTIMIENTO PARA RECIBIR TRATAMIENTO

Nombre del paciente____ Fecha de nacimiento_______________
Medico/Proveedor____

Solicito y autorizo tratamiento medico en la medida que el medico o sus representantes a cargo de mis cuidados lo consideren necesario y adecuado. Dichos cuidados pueden incluir procedimientos de diagnostico, radiologla y labortorio, asi como procedimientos terapeuticos, farmacos, cuidados de enfermeria y cuidados hospitalarios.

Mi Firma a continuacion indica la confirmacion de que he leld y aprobado la informacion anterior.

Firma del paciente/ tutor____

Fecha____

Joan T. Meaney, M.D., P.A

HIPPA Acknowledgement/ Consent to the use and disclosure of health information for treatment, payment, or healthcare operations.

I understand that as a part of my healthcare, Joan T. Meaney, M.D., P.A. originates and maintains health care records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals that contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgement. I understand that Joan T. Meaney, M..D., P.A. reserves the right to change its practices and to make the new provisions effective for all protected health information maintained by Joan T. Meaney, M.D., P.A.

I understand that I have the right to request restrictions as to how my protected heal information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Joan T. Meaney, M.D.,P.A. is not required to agree to the restrictions requested. Joan T. Meaney, M.D.,P.A will not use or disclose your health information without your authorization, except as described in the Notice of Privacy Practices.

Joan T. Meaney, M.D.,P.A records may contain information created by an entity other that Joan T. Meaney, M.D.,P.A . Joan T. Meaney, M.D.,P.A is not responsible for the information contained therein (including the accuracy, completeness, relevance, legibility, or lack thereof if such incorporated records). Patient expressly requests release of all records maintained by Joan T. Meaney, M.D.,P.A concerning patient, including incorporated records. Patient acknowledges that Joan T. Meaney, M.D.,P.A has no and assumes no duty to patient regarding the content of or omissions from such incorporated records.

Patient Signature or Legal Representative X____ Date: ________________

Parent or Guardian Signature X____ Date: ________________________

Joan T. Meaney, M.D., P.A was unable to obtain acknowledge/consent because:

- ☐ Patient confused/ Disoriented
- ☐ Patient Refused, Reason____
- ☐ Patient disability requires additional outside education/ Interpretation from other that Joan T. Meaney, M.D., P.A.
- ☐ Patient received acknowledgement/ consent packet and requests to take home, read, sign, and return to Joan T. Meaney, M.D., P.A.
- ☐ Patient Restrictions ____

Joan T. Meaney, M.D., P.A.
Urology
7434 Louis Pasteur Dr. Ste. 215 San Antonio, Texas 78229
Phone: (210)463-9642   Fax (855)783-1225

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: ____

____

____

Please release the above named physician:

_____ Last Office Visit Note

_____ Most Recent Labs and X-Ray reports

_____ Entire Medical Record

Patient's Name: ____ DOB: ________/________/________

Address:

____

____Phone: (_______)_______-__________

____

Patient Signature   Date

____

Printed Name   Date

Urology with Dignity, P.A.
Joan T. Meaney, M.D., P.A.

CANCELLATION/ NO SHOW POLICY

Our goal is to satisfy you, our patients, with exceptional care. Whether you are seeing us for a problem visit or just your yearly checkup. We take the time to discuss the issues you may have and answer your questions. We value our patients and the time we spend with each of you, we would like to set aside appointments that work for your schedule. Our office hours are 8:30am to 4:00pm Monday through Friday. If there is a conflict with your scheduled appointment time, we ask that you call our office at least 24 hours from the time of your appointment in advance to cancel or reschedule. When you schedule an appointment, we cannot offer that time slot to other patients needing to be seen. For this reason, appointments cancelled without a 24-hour advanced notice or if you are a no show, you will be charged a $25 fee. Please note if we do not answer or if it is a weekend, you may leave a voicemail to avoid the fee.

By signing this letter, you are stating you have read and understand the appointment cancellation/ no show policy outlined on this page and have no further questions.

Patient Name (Print)____

Patient Signature_____________________________________Date____/____/____

7434 Louis Pasteur Dr. #215 San Antonio TX 78229 Office: (210)463-9642 Fax (855)783-1225
www.joanmeaneymd.com

Urinary Symptom Screener (AUA Symptom Score)

*****For Office Use Only*****
Prior Balance: $___________
Due Today: $_____________
Total Due: $____________
Payment By: Cash, Credit, Check#_______
Amount Paid: $________

Patient Name:_______________________________________ **Date**___/___/___

Circle the number that best describes your experience.	Not at all	Less than 1 time in 5	Less than 1/2 the time	About 1/2 the time	More than 1/2 the time	Almost Always
1.Incomplete Emptying Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
2. Frequency Over the past month or so, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3.Intermittency Over the past month or so how often have you found that you stopped and started again several times when you urinated?	0	1	2	3	4	5
4.Urgency Over the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5.Weak Stream Over the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
6.Straining Over the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7.Nocturia Over the past month or so, how many times did you typically get up to urinate from the time you went to bed to the time you got up in the morning?	0	1	2	3	4	5

Add the score for each question above, and write the total in the space to the right.

Symptom score=1-7 Mild 8-19 Moderate 20-35 Severe **TOTAL**_________________

QUALITY OF LIFE: How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?

0	1	2	3	4	5	6
Delighted	Pleased	Most Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible

PLEASE CONTINUE TO BACK--->

Urology With Dignity, P.A.

7434 Louis Pasteur Dr. Ste.215
San Antonio, Texas 78229-3714

O'Leary-Sant Interstitial Cystitis Symptom and Problem Questionnaire

Symptom Index	Problem Index
1.In the past month, How often have you felt the strong need to urinate with little or no warning? 0___not at all 1___less than 1 time in 5 2___less than half the time 3___about half the time 4___more than half the time 5___almost always 2.During the past month, have you had to urinate less than 2 hours after you finished urinating? 0___not at all 1___less than 1 time in 5 2___less than half the time 3___about half the time 4___more than half the time 5___almost always 3.During the past month, how often did you most typically get up at night to urinate? 0___none 1___once 2___2 times 3___3 times 4___4 times 5___5 or more time 4.During the past month, have you experienced pain or burning in you bladder? 0___not at all 1___a few times 2___almost always 3___fairly often 4___usually Total Score:_______ (add all questions in the column) IC>,=6, controls <6	During the past month, how much has each of the following been a problem for you? 1.Frequent Urination during the day? 0___no problem 1___very small problem 2___small problem 3___medium problem 4___big problem 2.Getting up at night to urinate? 0___no problem 1___very small problem 2___small problem 3___medium problem 4___big problem 3.Need to urinate with little warning? 0___no problem 1___very small problem 2___small problem 3___medium problem 4___big problem 4.burning, pain, discomfort, or pressure in your bladder? 0___no problem 1___very small problem 2___small problem 3___medium problem 4___big problem Total Score:_____ (add all questions in the column) IC>,=6,controls<6