Urology Associates, Inc.

Patient Information

First Name______________________________ Last Name________________________________ M.I.______

Street Address__________________________________ City_____________________ State_____ Zip________

Social Security #________________________ Male_____ Female_____ Date of Birth______________________

Marital Status (circle one): Single Married Divorced Widowed Partner E-mail address____________________

Race (circle one): White Black Hispanic Native American Asian Other (please specify)________________
Preferred Language (if other than English) _____________________

Home Phone ____________________ Work Phone___________________ Cell/Other_____________________

Employer Name________________________ Employer Phone________________ Occupation________________

Employer Address____ If Student: Full Time___ Part Time___

Spouse/Nearest Relative

Name____________________________________ DOB____________ Relationship to patient_____________

Address____ Employer_______________________

Home Phone____________________ Work Phone____________________ Cell/Other____________________

Emergency Contact

Name____________________________________ DOB____________ Relationship to patient_____________

Home Phone____________________ Work Phone____________________ Cell/Other____________________

Insurance Information

Primary Insurance_____________________ ID#_________________ Group#_________________

Subscriber Name________________________ Subscriber DOB____________ Relationship to patient

Secondary Insurance___________________ ID#_________________ Group#_________________

Subscriber Name________________________ Subscriber DOB____________ Relationship to patient______

Other Information

Pharmacy Name, Location and Phone Number____

Referring Doctor______________________________ Primary Care Doctor______________________________

____

Authorization: I certify that the information on this form is true and accurate to the best of my knowledge. I also understand that this information may be used by Urology Associates to establish primary insurance coverage and to answer questions the insurance carriers listed may have regarding pre-existing conditions. I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to Urology Associates, Inc. or any individual provider it may designate for services rendered.

Privacy Notice Acknowledgement : I understand that Urology Associates, Inc. has a published Privacy Policy and that I am entitled to a copy at my request.

Financial Policy Acknowledgement: I have been provided a copy of Urology Associates' Financial Policy. I have read and agree to the terms of the policy.

Signature of Patient or Parent/Guardian of Minor__________________________________ Date_______________

Name: ____ **Date:** _________________ **DOB:**____________________

Referring Doctor: ________________________________ **Family Doctor:** ________________________________

Why are you seeing the doctor today? ____________________________________ How long have you had this problem? ______________________

ALLERGIES – **Please list ALL types (Drug, seasonal, pets, environmental foods):**

____

CURRENT MEDICATIONS – **List ALL medications you are currently taking, including over the counter meds & supplements. (Attach list or write on back of sheet if necessary)**

Drug Name:	Dosage:	Directions/How you take it:
____________________________	____________	____
____________________________	____________	____
____________________________	____________	____
____________________________	____________	____
____________________________	____________	____
____________________________	____________	____

Pharmacy Name: ____________________________________ **Phone #:** ____

REVIEW OF SYSTEMS: **Please circle if you have *recently* experienced any of the following:**

Constitutional
Fever
Fatigue
Generalized Weakness
Weight Gain
Weight Loss

Eyes
Blurred Vision
Cataracts
Glasses
Glaucoma
Worsening Eyesight

Allergic/Immunologic
Animal Allergies
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

Neurological
Balance Problems
Disoriented
Dizzy Spells
Headache
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems
Tremors

Metabolic
Diabetes
Excessive thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too Hot/Cold

Gastric/Intestinal
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/heartburn
Irregular Bowel Movements
Nausea/vomiting
Rectal Bleeding
Tarry Stool

Heart/Cardiovascular
Chest Pain/Angina
Difficulty Breathing w/exertion
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse
Pain/Cramps Hips/Legs w/exercise
Palpitation
Skipped Heart Beats
Swelling

Skin
Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin rash

Musculoskeletal
Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness

Ear/Nose/Throat
Ear Infection
Sinus Problem
Sore Throat

Genitourinary
Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Enuresis
Not Emptying
Painful Ejaculation
Stranguria
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream

Respiratory
Asthma
Emphysema-Bronchitis
Environmental Allergies
Frequent Cough
Pneumonia
Shortness of breath
Tuberculosis
Wheezing

Hematological/Lymphatic
Swollen Glands
Blood clotting problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell

Psychologic
Anxiety
Depressed
Generally satisfied with life

PAST MEDICAL HISTORY Please CIRCLE if you have or have had any of the following diseases or conditions:

Heart/Vascular
Angina (Chest Pain)
Arrhythmia (Irregular Heartbeat)
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Enlarged Heart
Heart Attack
Heart Disease
Heart Murmur
Hypertension, well controlled
Hypertension, progressive
Hypertension, severe
Stroke

Any other heart problems or conditions:__________
____
____
____

Metabolic
Diabetes Mellitus, non-insulin dependent
Diabetes Mellitus, insulin dependent
Diabetes Mellitus, uncontrolled
Goiter
Gout
Hyperthyroidism
Hypothyroidism

Any other metabolic conditions: ____________
____
____

General
Allergies
Hepatitis A
Hepatitis B
Hepatitis C
Hypercholesterolemia (High cholesterol)
Obesity
Sleep Apnea

Any other general diseases or conditions:_____________
____
____

Gastric/Intestinal
Gall Bladder Disease
Gallstones
Chronic Liver Disease
Constipation
Crohn's Disease
Diarrhea
GERD/Acid Reflux
Hemorrhoids
Liver Disease
Ulcer (specify location):

Any other gastric/intestinal diseases or conditions:
____
____
____

Genitourinary
AIDS
Bladder Cancer
Bladder Infection
Chronic Kidney Failure
Erectile Dysfunction
Blood in Urine
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones
Penile Discharge
Prostate Cancer
Testicular Cancer
Transplant Recipient
Venereal Disease

Any other genital/urinary diseases or conditions:
____
____
____

Female Genital/Reproductive
Breast Cancer
Breast Disease
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer

Any other female reproductive diseases or conditions:_____________

Head, Eyes, Ears, Nose
Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Ringing in ears
Vertigo
Glasses
Contacts
Hearing Aids

Any other diseases or conditions of the head, eyes, ears, nose or throat:________________
____
____

Musculoskeletal (Back, Limbs)
Arthritis
Back Pain
Carpal Tunnel Syndrome
Fibromyalgia

Any other diseases/condition of the musculoskeletal system:
____
____
____

Neurological
ADHD
Alcoholism
Alzheimer's disease
Anxiety
Bi-polar Disorder
Depression
Eating Disorder
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Parkinson's
Seizures
Spinal Cord Injury
Stroke

Any other neurological diseases or conditions:_____________
____

Respiratory
Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia
Pulmonary Embolism
Tuberculosis (TB)

Any other respiratory diseases or conditions:
____
____
____

Tumors
Brain Cancer
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Fibrocystic Breast Disease
Stomach Cancer
Throat Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Kidney Cancer
Testicular Cancer
Bladder Cancer
Ureter Cancer
Uterine CA

Any tumors of other areas:
____
____
____
____

Date of Last: Menstrual Period___________ Pap Smear___________ Colonoscopy___________

Number of Pregnancies:_________ Live births:___________

 Patient Name____

SURGICAL HISTORY

If you have had any surgeries, please indicate the date and the type of procedure:

Heart/Cardiovascular:

Type of Surgery: ___________________________________
Date(s):________________________________

Type of Surgery: ___________________________________
Date(s):________________________________

Gastric (Stomach)/Intestinal:

Type of Surgery:___________________________________
Date(s):________________________________

Type of Surgery;___________________________________
Date(s):_______________________________

Type of Surgery:___________________________________
Date(s);_______________________________

Urologic/Genitourinary:

Type of Surgery:___________________________________
Date(s):________________________________

Type of Surgery:___________________________________
Date(s):________________________________

Type of Surgery:___________________________________
Date(s):________________________________

Type of Surgery:___________________________________
Date(s):________________________________

Female Genital/Reproductive:

Type of Surgery:___________________________________
Date(s):________________________________

Type of Surgery:___________________________________
Date(s):________________________________

Type of Surgery:___________________________________
Date(s):________________________________

Head, Eyes, Ears, Nose, Throat:

Type of Surgery:_____________________________________
Date(s):________________________________

Type of Surgery:_____________________________________
Date(s):________________________________

Musculoskeletal (Back, Limbs):

Type of Surgery:_____________________________________
Date(s):________________________________

Type of Surgery:_____________________________________
Date(s):________________________________

Type of Surgery:_____________________________________
Date(s):________________________________

Respiratory (Lung):

Type of Surgery:_____________________________________
Date(s):________________________________

Type of Surgery:_____________________________________
Date(s):________________________________

Skin:

Type of Surgery:_____________________________________
Date(s):________________________________

Type of Surgery:_____________________________________
Date(s):________________________________

Please list any other types of surgeries not previously listed, with dates: ____________________________________
____
____
____
____
____

FAMILY HISTORY

Please indicate which family member has/had any of the following: (Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt)

Arthritis __________________________
Bedwetting __________________________
Bladder Cancer __________________________
Cancer (site unknown) ________________
Crohn's Disease __________________________
Depression __________________________
Diabetes __________________________
Gout ____________________________
Heart Attack ____________________________
Hypertension ____________________________
Kidney Cancer ____________________________
Kidney Disease ____________________________
Leukemia ____________________________
Malignant Melanoma______________________
Multiple Sclerosis ______________________
Laryngeal Cancer______________________
Pancreatic Cancer ______________________
Prostate Cancer ______________________
Stroke ____________________________
Thyroid Disease ______________________
Tuberculosis ________________________

SOCIAL HISTORY

Marital Status: Please indicate years

Single______ Married______ Separated_____ Divorced______ Widowed_____ Life Partner______ Common Law Spouse_____

Occupation:___________________________________

Alcohol Consumption: _____None _____Yes ____Occasional/Social # of drinks per day _______

Tobacco per day: _____None ______Yes #______Packs/day ______Cigarettes/day _____Smokeless Tobacco

If you previously smoked, when did you quit? ____________ **Caffeinated beverages:** None Low Moderate Excessive

Urology Associates, Inc.

In the event that a patient wishes another individual to receive medical information such as test results, etc., or in the event that the patient is unable to receive those results, the patient may choose to designate persons who are authorized to receive that information.

I hereby authorize the release of my medical health information to the following designated persons:

( ) Spouse Name ______________________________

( ) Son Name ______________________________

( ) Daughter Name ______________________________

( ) Parent Name ______________________________

( ) Other Name ______________________________

** Permission to leave lab/test results on my answering machine or voice mail: (Please circle) Yes No

I understand that if I wish to revoke this authorization at any time, the request for revocation must be made in writing to Urology Associates, Inc.

If I do not indicate a designated person to receive information, I am requesting that medical information be released only to me.

Patient Signature ______________________________

Printed Name ______________________________

Date __________________________

UROLOGY ASSOCIATES, INC.
FINANCIAL POLICY

PLEASE READ CAREFULLY:

The physicians and staff of urology associates, inc., are committed to providing you with the best possible care. In order to help you receive your maximum allowable benefits from your insurance coverage, we need your assistance as well as your understanding of our financial policy.

Insurance Patients:

- Payment of co-pay and deductible is due in full at the time of your appointment. We accept cash, checks, MasterCard, Visa and Discover.
- We must emphasize that as medical providers, our relationship is with **you**, not your insurance company. Your insurance is a contract between you, your employer, and the insurance company. While the filing of claims is a courtesy that we extend to our patients, all charges are **your** responsibility from the date the services are rendered.
- Some insurance plans require referrals or pre-authorization. ***You*** will need to obtain authorization prior to your appointment date. We **cannot** treat you without an authorization if it is required.
- Not all services are a covered benefit, depending on your individual insurance policy. It is your responsibility to familiarize yourself with your benefit coverage. This includes knowing which facilities are in-network for lab, radiology, and surgical procedures in the event that we need to refer you for additional services.
- Some services provided by the clinic are not billable to your insurance and will be your responsibility. This includes charges for completing paperwork that is not directly related to your treatment (i.e., cancer policy paperwork, DHS applications, etc.) as well as after-hours phone calls and copying medical records.
- If surgery is required, you will be contacted prior to your procedure to collect the estimated deductible and coinsurance amounts. Payment for your portion is due two days prior to the surgery date.

Medicare Patients:

- We will file Medicare and any supplemental insurance for your services. Any coinsurance or deductible that remains will be billed directly to you.
- Some services provided by the clinic are not billable to your insurance and will be your responsibility. This includes charges for completing paperwork that is not directly related to your treatment (i.e., cancer policy paperwork, DHS applications, etc.) as well as after-hours phone calls and copying medical records.
- If the doctor plans to run a test or perform a procedure that may not be covered by Medicare, you will be informed in advance and asked to sign a waiver for these services.

NO SHOW POLICY:

You may be charged a fee if you do not show for your appointment. We make every effort to call and remind you of your appointment. However, it is ultimately the patient's responsibility to remember their appointment. Please call our office to cancel or reschedule your appointment to avoid this fee.

Continued on Reverse

For those patients without insurance:

OFFICE CHARGES:

- Payment in full is due at the time of your appointment.
- Payment can be made by cash, Visa, MasterCard, or Discover only.

SURGERY CHARGES:

- In the event your doctor determines that surgery is necessary, a down payment of at least 50% of your *estimated* charges is due two days prior to the date of surgery. Arrangements to pay the balance of your account must also be made with our billing office at that time.
- Minimum monthly payment amounts must be approved by the billing office to assure the account is paid in a timely manner. Payments must be received every month in order to keep the account in good standing.
- Surgical procedures that are considered to be elective (i.e., vasectomies, circumcisions, etc.) must be paid *in full* prior to the date of the surgery.
- For your convenience, we do accept credit card payments by phone.

We realize that medical costs can sometimes create a financial hardship. We are eager to help patients settle their accounts in a manner that is agreeable and manageable for both parties. Please contact our billing office with any questions.

MEDICATION REFILL POLICY

Medication questions and requests for additional medication from our patients are important issues that are taken very seriously by our physicians and staff. Please adhere to this policy so that we may give you the best care possible.

HOW TO REQUEST A REFILL:

-Contact your pharmacy and request a refill.
-Give your pharmacy our fax number: 405-749-1001. They will fax us an authorization.
-Allow 2 business days to process your request.
-Your physician must approve the refill before it can be completed.

MEDICATIONS WILL NOT BE REFILLED:

-After 12:00 (noon) on Fridays. Please plan ahead if you will run out over the weekend.
-On weekends, holidays, or after hours.
-If you continue to miss scheduled appointments.
-Within two (2) days of a scheduled office visit. Ideally, refills should be discussed with your physician at regularly scheduled appointments.

Thank you for your assistance in helping to meet your medication refill needs.

DRUG SCREENING: The physicians at Urology Associates may perform urine drug screens when deemed necessary for patient care and management.