Alaskan Interior Urology

1305 21st Ave, Suite 101
Fairbanks, AK 99701
Tax ID 26-3251875

ADULT REGISTRATION FORM

Do you wish your family financial record to be listed in the patient or spouse name? Please check one: ❑Patient ❑Spouse

PLEASE PRINT

PATIENT INFORMATION

Patients Name	Date of Birth	Sex	Social Security No.

Mailing Address	City	State	Zip	Home Phone

Employer (If self, name of business)	Dept./Position Held	Union/Local No.	Work Phone/Ext

In case of emergency notify:	Address	Relationship	Phone

SPOUSE INFORMATION

Spouse Name	Date of Birth	Sex	Social Security No.

Mailing Address	City	State	Zip	Home Phone

Employer (If self, name of business)	Dept./Position Held	Union/Local No.	Work Phone/Ext.

COMPLETE FOR EACH COMPANY (please bring your insurance card to the appointment)

Insurance Company	Primary Insurance	Secondary Insurance	Tertiary Insurance	Other Insurance
Insurance Address				
Identification No. Policy or Group No.				
Family Members Covered				
Policy Holder's Name				
Policy Holder's SSN				
Relationship to Patient				

AUTHORIZATION: I understand full payment received is my responsibility regardless of my insurance coverage. I hereby authorize the Clinic to release my insurance information acquired in the course of examination or treatment. I further authorize my insurance company to pay directly to the Clinic any medical/surgical benefits due to me that have not been paid in full. This authorization shall expire upon written notice or one year from this date.

SIGNATURE	Date
UPDATE	Date
UPDATE	Date

OVER

HIPAA CONSENT FORM

I give Alaskan Interior Urology, LLC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Alaskan Interior Urology, LLC's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Alaskan Interior Urology, LLC is not required to agree to the request. If Alaskan Interior Urology, LLC agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

Signature: _____ **Date:**_____

Patient, parent or guardian

Please list any family member(s) that you would like to allow us to discuss your medical treatment and care with:

_____

If signed by patient representative, state relationship to patient: _____

ALASKAN INTERIOR UROLOGY
1305 21ST AVE, STE 101
FAIRBANKS, AK 99701
907-458-0700

A clear understanding of your financial responsibility for care is essential in assuring a professional relationship with our staff. Please read this form carefully and have your questions answered before signing.

Payment: We accept cash, checks or visa and master card.

Insurance: Remember-You are ultimately responsible for your bill. If you have private insurance, as a courtesy, we will bill your Insurance for our services once per visit or procedure. All patients are asked to pay the full amount for services at the beginning of each year until deductible is met. You will then be expected to pay your "co-pay" at each following visit. Any overpayments will be refunded to the appropriate party. If there is a balance left after your insurance has paid, you will be billed; that amount is due upon receipt of your first statement from our office. If your Insurance has not paid for any reason, you will be billed and are responsible for the charges on receipt of your first statement from our office. Please remember that insurance is a contract between you and your insurer. We will be happy to help if we can but will not become involved in disputes concerning deductible, co-payments, secondary insurance or so-called "usual and customary" reductions by your insurer.

Medicare Patients: Please remember that you have a yearly deductible and co-pay for each visit. Medicaid Patients: Please be prepared to pay your $3.00 co-pay at time of service.

Veteran's Administration Patients: You are required to get PRE-AUTHORIZATION before each visit if you want VA to pay. A 5 day notice is now required by VA; it is your responsibility to see this is done. VA authorization must be received in our office before each visit. If no authorization is received, you will be expected to pay in full at the time of vow vklt.

Chief Andrew Isaac Health Center Patients: You must bring a purchase order from Contract Health for each and every visit. This is their requirement for us to be paid. If no purchase order is provided, you will be expected to pay at the time of service unless you have Medicaid coupons.

Workers Compensation: No retroactive filing will be done by our office. If it is work-related, you must state that at the time of service and be prepared will all necessary information.

No Abgnii If you fail to cancel and do not show for any appointment, you will be charged a $30 fee. This fee will be billed directly to you and not your insurance. After 3 no shows, no further appointments will be made for you. Mail Returns (no forwarding address): Upon return to our office, these accounts will be sent immediately to our Collection Agency.

Delinquent Accounts: Past due accounts may be referred to our Collection Agency for collections. You will be responsible for all collection fees incurred in addition to the past due balance. There will be a 50% handling fee added if your account is sent to collections. Once an account has been placed with the Collection Agency, all questions must be directed to their office. Additionally we will not be liable for any consequences which may result from a collection agency's effort to obtain payment.

Printed Name **Signature** **Date**

OVER

ALASKAN INTERIOR
UROLOGY ASSIGNMENT
OF BENEFITS

I authorize and request that payment be made to Alaskan Interior Urology for services rendered. I agree that this authorization will cover *all* medical services rendered until such authorization is revoked by me. A copy of this form may be used in lien of original document.

Your insurance company may request chart notes in order to process your claim. By signing below, you are authorizing us to release pertinent clinical information to your insurance company.

_____

Patient Signature

_____

Parent Signature (if patient is minor child)

_____

Date

UROLOGY - Patient information

Name: _____ Date: _____

Referring Doctor: _____ Family Doctor: _____

Why are you seeing the doctor today? _____

_____

How long have you had this problem/pain? _____

What improves/worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

_____

Is the problem/pain continuous, or does it come and go? _____

_____

What is the nature of the pain? (sharp, dull, etc.) _____

Have you tried any medicine/treatment or seen a doctor for this problem before this visit? _

_____

_____

Review of Genitourinary Systems

Please mark with and 'x' if you have or have ever had any of the following:

- ❑Back Pain
- ❑Bedwetting
- ❑Blood In Urine
- ❑Dribbling
- ❑Burning on urination
- ❑Erection/Ejaculation problem
- ❑Flank pain
- ❑Kidney failure
- ❑Kidney infections
- ❑Kidney stones
- ❑Leak after voiding
- ❑Up at night to urinate
- ❑Not emptying
- ❑Painful ejaculation
- ❑Stones
- ❑Suprapubic Pain
- ❑Testes/Scrotal Swelling
- ❑Urgency
- ❑Urinary Frequency
- ❑Urinary Hesitancy
- ❑Urinary Incontinence
- ❑Urinary Tract Infection
- ❑Urine Retention
- ❑Urologic Cancer
- ❑Urologic Surgery
- ❑Vaginal Bleeding
- ❑Vaginal Discharge/Problems
- ❑Weak stream
- ❑Other_____

_____

_____

_____

_____

OVER

Review of Systems

Please mark with a 'x' if you have:

Constitutional
- ❑Fever
- ❑Chills
- ❑Appetite Change
- ❑Night Sweats
- ❑Fatigue
- ❑Weight Loss
- ❑Other_____

Eyes
- ❑Blindness
- ❑Blurred vision
- ❑Glaucoma
- ❑Other_____

Neurological
- ❑Stroke
- ❑Headache
- ❑Dizzy spells
- ❑Numbness/tingling
- ❑Leg or arm weakness
- ❑Memory loss
- ❑Other_____

Endocrine
- ❑Diabetes
- ❑Pituitary disease
- ❑Thyroid disease
- ❑Other_____

Gastrointestinal
- ❑Acid reflux
- ❑Indigestion/heartburn
- ❑Nausea/vomiting
- ❑Abdominal pain
- ❑Bloody stools
- ❑Diarrhea
- ❑Constipation
- ❑Rectal bleeding
- ❑Hemorrhoids
- ❑Other_____

Cardiovascular
- ❑Chest pain/angina
- ❑Palpitation
- ❑Heart attack
- ❑Heart failure
- ❑Heart murmur
- ❑High blood pressure
- ❑Irregular heartbeat
- ❑Other_____

Skin
- ❑Skin rash
- ❑Other_____

Musculoskeletal
- ❑Back pain
- ❑Joint pain
- ❑Muscle cramps
- ❑Arthritis
- ❑Other_____

Ears/Nose/Throat
- ❑Ear infection
- ❑Sinus Problems
- ❑Other_____

Respiratory
- ❑Asthma
- ❑Emphysema-Bronchitis
- ❑Frequent cough
- ❑Shortness of breath
- ❑Other_____

Hematologic/Lymphatic
- ❑Swollen glands
- ❑Blood dotting problem
- ❑Bleeding problems
- ❑Hepatitis
- ❑HIV (AIDS)
- ❑Sickle Cell
- ❑Other_____

Psychological
- ❑Anxious
- ❑Depressed
- ❑Generally satisfied with life
- ❑Other_____

For each of the eight questions below, please check the one box that best describes your symptoms.

*Name:*_____ ********PLEASE BE SURE TO COMPLETE BOTH SIDES!********

The International Scientific Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), has agreed to use the symptom index for BPH, which has been developed by the American Urological Association (ALLA) Measurement Committee. as the official worldwide symptoms assessment tool for patients suffering from prostatism.	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
Intermittency Over the past month, how often have you found you stopped and started again sever times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**
Urgency Over the past month, how often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**
Weak Stream Over the past month, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
Straining Over the past month, how often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**
Nocturia Over the past month, how many times did you get up to urinate from the time you went to bed until the time you got up?	**0**	**1**	**2**	**3**	**4**	**5**
Quality of Life Due to Urinary Symptoms	**Delighted**	**Pleased**	**Mostly Satisfied**	**Mixed**	**Mostly dissa-tisfied**	**Terrible**
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 that?	**0**	**1**	**2**	**3**	**4**	**5**

Past Medical History

Please mark with an 'x' if you have any of the following diseases or conditions:

- ❑Alcoholism
- ❑Alzheimers Disease
- ❑Anemia (type) _____
- ❑Angina
- ❑Anxiety
- ❑Arthritis
- ❑Arrhythmia
- ❑Aortic aneurysm
- ❑Asthma
- ❑Atrial fibrillation
- ❑Bleeding disorder
- ❑Bronchitis
- ❑Chronic fatigue syndrome
- ❑Colitis
- ❑Constipation
- ❑Crohn's disease
- ❑Depression
- ❑Diabetes mellitus
- ❑Emphysema
- ❑Epilepsy
- ❑Fibromyalgia
- ❑GERD
- ❑Glaucoma
- ❑Gout
- ❑Heart Attack
- ❑Heart Disease _____
- ❑Heart murmer
- ❑Hemorrhoids
- ❑Hepatitis
- ❑Herniated disc
- ❑Hiatal hernia
- ❑Hypertension
- ❑Irritable bowel disease
- ❑Kidney Disease
- ❑Kidney infection
- ❑Migraine
- ❑Mitral stenosis
- ❑Mitral insufficiency
- ❑Mitral valve prolapse
- ❑Osteoporosis
- ❑Peptic ulcer
- ❑Phlebitis
- ❑Prostatitis
- ❑Prostate Cancer
- ❑Rheumatic fever
- ❑Stroke
- ❑Transplant Recipient
- ❑Tuberculosis
- ❑Cancer type: _____
- ❑Other: _____
_____

Surgical History

Please list all surgeries you have had and note the date:

_____
_____
_____
_____

Family History

Please indicate which family member has / had any of the following:

❑ Bedwetting_____ ❑ Bladder cancer _____ ❑ Breast cancer_____
❑ Cervical cancer _____ ❑ Colon cancer _____ ❑ Diabetes mellitus_____
❑ Kidney Cancer _____ ❑ Kidney Stones _____ ❑ Prostate Cancer_____

Social History

Marital Status

❑Single ❑Married/#years_____ ❑Separated ❑Divorced ❑Widowed ❑Life Partner

Dependents: Please indicate # of children you have.

____Sons ____Daughters ____Stepchildren Other: _____

Occupation:

Please circle one that applies: None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired Description: _____

Alcohol Consumption: ___None ___Yes ___Occasional/social _____# of drinks per day

Tobacco per day: ___None ___Yes ___Cigarettes ___Pipe ___Smokeless Tobacco
If yes: _____#packs/day _____#cigarettes/day _____#yrs/smoked
If you previously stopped, when? _____ How long? How much? _____

Recreational drugs: ___None If yes, please list: _____

Caffeinated beverages: ___None ___Low ___Moderate ___High/Excessive
____Coffee _____#cups/day _____Soda _____#cups/day

Recent Foreign Travel (please circle all that apply)

None
Americas: Canada, Mexico, Latin America, South America, Other_____
World Wide: Europe, Africa, Middle East, Asia, Australia, Other _____

Current Medications

Please list ALL medications you are currently taking. Include any over-the-counter drug (s).

Drug Name Strength Directions/How you take it

_____
_____
_____
_____
_____
_____
_____
_____

Pharmacy Name: _____**Phone #:** _____

Allergies: Please list ALL types (drug, seasonal, pets, animals, environmental, foods)

_____
_____
_____
_____