CASCADES UROLOGY CENTER

Date:___/___/___

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

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

Age: _____ Date of Birth: _____/_____/_____ Marital Status: S M D W Referral: _____

HISTORY OF THE PRESENT ILLNESS

What is the main reason for your visit to our office (Describe your problem in detail)_____

_____

When did you first noticed the problem? Days _____ Weeks _____ Months _____ Other _____
How long does the problem last? Minutes _____ Hours _____ Constant _____ Other _____
Is anything else occurring at the same time? Nausea _____ Bleeding _____ Fever _____ Other _____
Have you had similar problem in the past? No _____ Yes _____ How long ago? _____ Any treatment? _____

PLEASE MARK/ CIRCLE ALL THAT APPLY *Office use: Sto( )-Blo( )-Dys( )-UTI( )-GU surg( )-AUASx( )-PSA( )*

Past MEDICAL ILLNESSES that apply: **If NONE, please mark here ( )**

( ) – Bladder infection # times: _____ Symptoms: burning / frequency / pressure / blood in urine / antibiotic helped
( ) – Blood in the urine # times: _____ ( ) gross blood (urine was red) ( ) never gross blood, just microscopic
( ) – Elevated PSA Never had prostate biopsy: _____ Had previous prostate biopsy: ( )Benign ( )Malignant
( ) – Kidney stones # times: _____ Side: Right / Left ( ) Passed spontaneously ( ) Required surgery
( ) – Any urologic malignancy: _____
( ) – Problems urinating ( ) Difficulty urinating ( ) couldn't urinate and had catheter placed ( ) couldn't hold and needed pads
( ) Stroke ( ) Cancer: _____ ( ) Diabetes ( ) Glaucoma ( ) Heart problems ( ) High blood pressure
( ) Have children How many: _____ # times pregnant: _____ # Vaginal deliveries: _____ # C-Sections: _____ Other: _____
Other medical problems: _____
_____

Please list ALL previous SURGERIES that apply: **If NONE, please mark here ( )**

( ) – Kidney stone surgery: Type:_____ Side: Right____/Left____ # times:_____ Year(s)_____
( ) – Prostate surgery/biopsy Type:_____ ( )Benign ( )Malignant: Radiation___ Year:_____
( ) – Bladder suspension: Type: vag X abd How many times? ____ Year(s):_____
( ) – Hysterectomy: Type: vag X abd Year: _____ ( )Benign ( )Malignant: Radiation___/Chemo___
( ) – Ovaries removed : Both; R ; L
( ) – Vasectomy ( ) – Circumcision ( ) Scrotum/testicle surgery _____
( ) – Back surgery How many times: _____ ( )Cervical ( )Lumbar Year(s) ____
( ) – Any other urologic surgery:_____
( ) – **Any other surgeries**: _____

Please CIRCLE if you TAKE any of the following MEDICATIONS **If NONE, please mark here ( )**

Aspirin -Coumadin (warfarin) – Plavix - Motrin, Advil (ibuprofen) - Flomax - Uroxatral - Hytrin (terazosin) - Cardura (doxazosin) Minipress (prazosin) - Proscar (finasteride) - Avodart - Detrol – Ditropan (oxybutinin)- Oxytrol patch - Vesicare – Enablex – Levsin
Please list ALL other medications you are taking: _____
_____
_____

Please CIRCLE if you are *ALLERGIC* to the following MEDICATIONS **If NONE, please mark here ( )**

Codeine - Iodine topical – Iodine dye(x-ray contrast) – Latex - Lidocaine gel - Nitrofurantoin(Macrodatnin/Macrobid) - Penicillin – Sulfa(Bactrin) **What other medications are you allergic to?** _____
_____

PLEASE TURN THE PAGE

Please CIRCLE all FAMILY illnesses (add relationship if positive) **If NONE, please mark here ( )**

( ) Prostate Cancer _____ ( ) Kidney stones _____ ( ) Cancer _____ ( ) Diabetes _____

Other family illnesses: _____

Please MARK/CIRCLE what applies to your HABITS/PERSONNAL: **If NONE, please mark here ( )**

( ) Smoke cigarettes How much: _____ packs/day for _____years; Quit _____ years/months ago ( ) Never smoked

( ) Drink coffee / tea Regular_____ Decaf_____ How much: _____ cups/day

( ) Drink soft drinks ( ) Drink alcoholic beverages Other: _____

REVIEW OF SYSTEMS : Do you now or have you had any problems related to the following systems ? Circle **Y**es or **N**o

Allergies

Hay fever	Y	N
Drug allergies	Y	N
Other_____		

Cardiovascular

Chest pain	Y	N
High blood pressure	Y	N
Varicose veins	Y	N
Other_____		

Constitutional

Chills	Y	N
Fever	Y	N
Headache	Y	N
Other_____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sinus problems	Y	N
Sore throat	Y	N
Other_____		

Endocrine

Heat intolerance	Y	N
Tired/sluggish	Y	N
Other_____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain around the eyes	Y	N
Other_____		

Gastrointestinal

Abdominal pain	Y	N
Indigestion/heartburn	Y	N
Nausea/vomiting	Y	N
Other_____		

Genitourinary

Bloody urine	Y	N
Dribbling	Y	N
Slowing stream	Y	N
Urinary frequency	Y	N
Urinary frequency at night	Y	N
Urinary hesitancy	Y	N
Urinary retention	Y	N
Painful urination	Y	N
Urinary incontinence	Y	N
Other_____		

Hematologic

Blood clotting probl.	Y	N
Swollen glands	Y	N
Other_____		

Integumentary

Boils	Y	N
Persistent itch	Y	N
Skin rash	Y	N
Other_____		

Musculoskeletal

Back pain	Y	N
Joint pain	Y	N
Neck pain	Y	N
Other_____		

Neurological

Dizzy spells.	Y	N
Numbness/tingling	Y	N
Tremors	Y	N
Other_____		

Psychiatric

Depression	Y	N
Suicidal thoughts	Y	N
Other_____		

Respiratory

Frequent cough	Y	N
Shortness of breath	Y	N
Wheezing	Y	N
Other_____		

For Office Use:

BP: _____ Temp: _____

Pulse: _____ Height: _____

Weight: _____ Resp: _____

PLEASE TURN THE PAGE

CASCADES UROLOGY CENTER, INC.

REGISTRATION FORM

PATIENT'S FULL NAME _____

AGE: _____ DATE OF BIRTH: _____ **SOCIAL SECURITY #** _____

MALE (___) FEMALE (___) MARITAL STATUS: SINGLE (___) MARRIED (___) DIVORCED (___) WIDOWED (___)

ADDRESS: _____ HOME **PHONE** (_____) _____

CITY: _____ STATE: _____ ZIP **CODE**: _____ CELL **PHONE** (_____) _____

PATIENT'S **EMPLOYER** _____ **PHONE #** (_____) _____

SPOUSE OR BOTH PARENTS' NAMES (IF A CHILD) _____

SPOUSE/PARENT **EMPLOYER** _____ **PHONE #** (_____) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GUARDIAN (RESPONSIBLE FOR THE BILL) _____ **HOME PHONE** (_____) _____

ADDRESS: _____ CITY: _____ ZIP: _____ **WORK PHONE** (_____) _____

IN THE EVENT OF EMERGENCY :(SOMEONE OTHER THAN YOUR SPOUSE OR PARENT)

CONTACT_____RELATIONSHIP_____HOME PHONE_____WORK PHONE_____

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME_____ **POLICY #**_____ **GROUP#**_____

ADDRESS_____ POLICY HOLDER'S NAME_____

CITY_____STATE_____ZIP_____ DATE OF BIRTH_____

SECONDARY INSURANCE

NAME_____ **POLICY #**_____ **GROUP#**_____

ADDRESS_____ POLICY HOLDER'S NAME_____

CITY_____STATE_____ZIP_____ DATE OF BIRTH_____

FAMILY PHYSICIAN_____

REFERRING PHYSICIAN_____

PHARMACY NAME_____ PHONE # (_____) _____

HIPAA

(PLEASE INITIAL)_____I ACKNOWLEDGE RECEIPT OF "NOTICE OF PRIVACY PRACTICES" _____DATE

PLEASE TURN THE PAGE

RELEASE OF INFORMATION: PATIENT'S NAME _____

I hereby authorize that CASCADES UROLOGY CENTER, INC. can provide a report of my diagnosis, treatment, prognosis & recommendations, as well as other data pertinent to my treatment to my doctor_____

I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history and treatment to CASCADES UROLOGY CENTER, INC. and I understand that photocopies of this form are to be held as valid as the original.

PATIENT OR GUARDIAN SIGNATURE_____ DATE_____

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at each time of service exactly what those guidelines are. Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work, x-rays, or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. As the policy holder, YOU ARE RESPONSIBLE for knowing the benefits and restrictions of your insurance coverage.

WAIVER: I understand that should my insurance company require REFERRAL/AUTHORIZATION prior to my receiving Medical Service and I have not obtained this and/or this office has not received this, I WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

I hereby authorize the physicians of CASCADES UROLOGY CENTER, INC. to release information requested by my insurance company, any hospital or physician as needed. I hereby authorize assignment and payment directly to CASCADES UROLOGY CENTER, INC. for services rendered. I understand that I am responsible for any balance or charges that exceed or are not covered by my insurance carrier.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

SIGNATURE_____DATE_____

*A $25.00 CHARGE WILL BE COLLECTED FOR ALL RETURNED CHECKS.

MEDICARE LIFETIME SIGNATURE ON FILE

NAME OF BENEFICIARY_____

HIC NUMBER_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to CASCADES UROLOGY CENTER, INC. for any services furnished me by CASCADES UROLOGY CENTER, INC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. In Medicare nonassigned cases, the patient is responsible for the entire charge.

SIGNATURE OF THE PATIENT_____ DATE_____