WEST OHIO UROLOGY ASSOCIATES, 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:** _____ **WORK 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 OF 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 _____

DRUG ALLERGIES _____

PHARMACY NAME _____ PHONE # (_____) _____

PLEASE TURN THE PAGE

RELEASE OF INFORMATION: PATIENT'S NAME _____

I hereby authorize that WEST OHIO UROLOGY ASSOCIATES, 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 WEST OHIO UROLOGY ASSOCIATES, 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 WEST OHIO UROLOGY ASSOCIATES, INC. to release information requested by my insurance company, any hospital or physician as needed. I hereby authorize assignment and payment directly to WEST OHIO UROLOGY ASSOCIATES, 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 WEST OHIO UROLOGY ASSOCIATES, INC. for any services furnished me by WEST OHIO UROLOGY ASSOCIATES, INC. I authorize any holder of medical information about me to release to 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 by 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 _____

WEST OHIO UROLOGY ASSOCIATES
PATIENT HISTORY FORM

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 notice the problem? Days _____ Weeks _____ Months _____ Other _____

How long does the problem last? Minutes _____ Hours _____ Constant _____ Other _____

Is anything else occuring at the same time? Nausea _____ Bleeding _____ Fever _____ Other _____

Have you had a similar problem in the past? No _____ Yes _____ How long ago? _____ Any treatment? _____

PAST MEDICAL, SURGICAL & SOCIAL HISTORY

Please list **ALL MEDICAL ILLNESSES:**

Are you on any **MEDICATIONS?** Y N
If yes, please list all:

Please list **ALL PREVIOUS SURGERIES:**

Do you have **DRUG ALLERGIES?** Y N
If yes, please list all:

Please list serious **FAMILY** illnesses:
(Cancer, Diabetes, etc.)

Do you **SMOKE?** Y N

Do you have **CHILDREN?** Y N
If yes, how many? _____

If female: Are you **PREGNANT?** Y N
How many previous pregnancies? _____
Deliveries: Vaginal _____ C-Section _____

Do you **DRINK?**
Alcohol: Y N
Coffee Reg/Decaf: Y N
Soft Drink: Y N

PHYSICIAN USE ONLY:

Day Freq.	Noct.	Hesitancy	Intermit.	Burning	Urgency	Urg.Inc
P.V.D.	Bl. Emp. Y N	Infection	Gr. Blood Y N	Hx.Stone Y N	Flow	SUI STD

PLEASE TURN THE PAGE

Review of Systems

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

Please explain any Yes answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive heat	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other _____		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of Breath	Y	N
Other _____		

Hematological/Lymphatic

Swollen glands	Y	N
Blood clotting problems	Y	N
Other _____		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other _____		

Physician use only: (Comments/Notes)

Physician: _____ Date: _____/_____/_____