**NEW PATIENT INTAKE - ADULT FORM**

Welcome to Urology Associates, P.C. This questionnaire is intended to be a COMPLETE account of your medical history. Please answer completely, including details and dates, if known. Incomplete answers to these questions could lead to improper treatment.

**Chart:** ____________ **Date**_______________

**Name:** ___________________________ **Nickname:** ______________ **D.O.B:** ____________ Age: ____

**Address** (Street, City, State,Zip) ____________________________________________________________

**Home Phone:** ____________________ **Cell:** _______________________ **Work:** ________________

**Social Security#:** ______________ **Marital Status:** ______________ **Email:** ______________________

**Emergency Contact:** _________________________ **Relation to Patient:** __________________________

**Home:** _______________ **Cell:** _______________________ **Work:** __________________________

**Referring Dr.** ___________________________ **Primary Care Dr.** ____________________________

**Required Fields:** Not Reporting **Ethnicity:** Hispanic or Latino Not Hispanic or Latino

**Preferred Language:** _______________________________ **Race:** _______________________________

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**Pharmacy Name, Address, Phone** _________________________________________________________

**Why are you seeing the doctor today/Urologic Problems?**_______________________________________

**MEDICAL HISTORY** Height: ______ ft ________in Weight: ______________ lbs

**PAST MEDICAL HISTORY**

___ Arthritis
___ Back Pain
___ Bladder Prolapse
___ Colon Problems
___ Diabetes Mellitus
___ Difficulty Urinating
___ Emphysema
___ Gastric Reflux
___ Glaucoma
___ Gout
___ Heart Attack
___ Heart Disease
___ Hepatitis
___ Hernia
___ Hypertension
___ Kidney Failure
___ Kidney Stone
___ Liver Disease
___ Neuropathy
___ Pacemaker
___ Seizure Disorder
___ Stroke/TIA
___ Thyroid Problems
___ Thyroid Disease
___ Urinary Tract Infections
___ Ulcers
___ Uterine Prolapse
___ Vaginal Prolapse

Other Medical Problems:
_________________________
_________________________

**PAST SURGICAL HISTORY**

___ Brain
___ Sinus
___ Thyroid
___ Lung
___ Hernia
___ Breast
___ Gall Bladder
___ Intestine
___ Stomach
___ Appendix
___ Pancreas
___ Kidney
___ Bladder
___ Uterus
___ Fallopian Tubes
___ Ovaries
___ Prostate
___ Testes
___ Penis
___ Vasectomy
___ Back

___ Other Surgeries: _____________________________

**Do you have any replacement Joints?** __ No __ Yes:
___ Hip ___ Knee ___ Shoulder ___ Heart Valves

**Please give details of past surgeries checked**
_____________________________________________
_____________________________________________

**ALLERGIES** __Iodine __Latex __Shellfish ___ No known medication allergies

Medication Allergies______________________________________________________________

# Urology Associates, P.C.

PATIENT:______________________

**CURRENT MEDICATIONS** ____I currently take no medications.

List Medications with dose

1.______________________ 3______________________ 5______________________

2.______________________ 4______________________ 6______________________

Additional medications______________________________________________

**SOCIAL HISTORY** Alcohol use per week________________ Caffeine use per day ___________________

Tobacco Use: ___ Smoker: _____ packs per day ___ Former Smoker: quit _____ years ___ Never Smoked

**FAMILY HISTORY** **(please indicate family member diagnosed with the following)**

***M – mother, F - father, S – sister, B - brother, MG – maternal grandparent, PG – paternal grandparent***

____ Bladder Cancer ____ Diabetes ____ Liver Disease ____ Urethral Stenosis
____ Kidney Cancer ____ Heart Disease ____ Osteoporosis ____ UTI's
____ Prostate Cancer ____ Hypertension ____ Polycystic Kidney Disease ____ Other _______________
____ Testicular Cancer ____ Kidney Disease ____ Thyroid _______________

**REVIEW OF SYSTEMS** No symptoms at this time____

___ Chills ___ Rash ___ Constipation
___ Fatigue ___ Dizziness ___ Diarrhea
___ Fever ___ Swollen Glands ___ Nausea
___ Sweating ___ Cough ___ Vomiting
___ Weight Loss ___ Shortness of Breath ___ Blood in Urine / Blood in Stool
___ Itching ___ Chest Pain ___ Bleed Easily

**BOWEL FUNCTION QUESTIONNAIRE**

How often do you move your bowels?
___ times/day OR ___ times/week

Do you have trouble with constipation? Yes No

Do you ever have leakage of stool? Yes No

**UROGYNECOLOGIC QUESTIONNAIRE**

How many pregnancies? _____ Number of deliveries?_____

Do you feel as if your pelvic organs are "falling down?"Yes No

Do you feel a bulge at the opening of your vagina? Yes No

**URINARY QUESTIONNAIRE**

How often do you urinate? Every ____ hours during the day
I get out of bed ____ times a night

Do you loose urine in spurts with laughing, sneezing, or exertion? Yes No
What amount of urine do you lose? Small Large Both
In what position do you lose urine? Sitting Standing Lying down

Do you lose urine with a strong sense of urgency? Yes No

Does the sound, sight, feel of running water make you lose urine? Yes No

Do you lose urine without any warning (without activity or urgency)? Yes No

Do you wear a pad all the time? Yes No

Does your urine stream seem weak or slow? Yes No

Do you have pain associated with urination? Yes No

Do you have frequent bladder infections? Yes No

Is it difficult to get the urine stream started? Yes No

Do you feel that you empty your bladder completely? Yes No

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**(For Office Use Only)**

**ASSESMENT OF PLAN**

__Flow Rate __Bladder Scan __UA w/ micro ___Culture __Cytology __Lupron __BCG __Intron A __Mitomycin

# Urology Associates, P.C.

PATIENT:_________________________

## HIPAA NOTICE ACKNOWLEDGEMENT

*The Practice of Urology Associates, P.C. is required by applicable federal and state laws to maintain the* privacy of your health information. Protected health information (PHI) is the information we create and maintain in providing our services to you. Such information may include documentation of your symptoms, examinations and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law, the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to use and disclose your PHI for the purposes of treatment, payment and health care operations without your written authorization.

We will use your PHI during the course of your treatment if the physician determines we will need to consult with a specialist in another area. He will share the information with the specialist and obtain his/her input. We will also use your PHI to contact you by phone, if we need to speak to you about a medical condition, or to remind you of medical appointments. We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We also want you to know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. You may revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office (except to the extent action has already been taken based on a previous authorization).

You have the right to receive the Notice of Privacy Practices for Protected Health Information from our office or visit our website at www.uradenver.com. I acknowledge that I have been given the option to receive a copy of the Notice of Privacy Practices for the practice of Urology Associates, P.C.

## FINANCIAL SERVICE AGREEMENT

**BILLING PRACTICES:** Our policy is to bill the patient's insurance company for service rendered. However, Insurance coverage is another form of payment but ultimately it is your responsibility to pay for all services rendered. If you do not have insurance, payment is due at the time services are rendered. We will collect any known or estimated co-payments, co-insurance or deductibles at the time of service. Additionally, the responsible party will be billed for services rendered in full, should the insurance company deny coverage due to non-covered benefits, lack of referral, lack of proper reporting of incident/accident or lack of individual coverage, where applicable.

**COLLECTION ACTIVITY:** Any account balance(s) that are not paid within ninety (90) days from the date of service may be forwarded to a collection agency. If deemed necessary, Urology Associates PC reserves the right to forward the account balance(s) to a collection agency prior to ninety (90) days from the date of service. Any and all phone numbers provided to our office be it residential, employment or wireless, are authorized methods of communication by our office or by a collection agency in regards to any outstanding collection balances. Should litigation be necessary to collect an amount owed, the responsible party agrees to pay all costs of collection including, but not limited to, collection fees, attorney fees, interest and court costs.

**PAYMENT FOR SERVICES:** For payment of your financial obligation we accept Cash, Check, Visa, MasterCard or Discover.

If you have any questions or concerns, please speak with the billing dept. at (303)733-0662. ***Please note:*** *It is the patient's responsibility to understand their individual insurance benefits.*

I hereby assign to Urology Associates, PC all benefits for medical expenses. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I authorize the provider named above to release my medical records and all medical information requested by my insurance company.

_________________________ ______________ ______________

**Patient/Legal Guardian Signature** **Date** **Relation to Patient**

### CONSENT TO CONTACT/LEAVE INFORMATION

I authorize the staff of Urology Associates to speak with or leave a message regarding my results with the following individuals:

| Name | Relation to Patient | Phone Number | Speak with | Message/VM |
|---|---|---|---|---|
| Name | Relation to Patient | Phone Number | Speak with | Message/VM |
| Name | Relation to Patient | Phone Number | Speak with | Message/VM |

_________________________ ______________ ______________

**Patient/Legal Guardian Signature** **Date** **Relation to Patient**