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: _____

Birth Sex: __Male __Female **Preferred Pronoun Sex:** __Male __Female __Gender Neutral

Identifies as: __Male __Female __Transgender: __Male to Female or __Female to Male __Non-Conforming Gender

Address (Street, City, State,Zip) _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Occupation: _____ **Primary Phone:** (please circle one) Home / Cell / Work

Social Security#: _____ **Marital Status:** _____ **Email:** _____

Emergency Contact: _____ **Relation to Patient:** _____

Home: _____ **Cell:** _____ **Work:** _____

Referring Dr. _____ **Primary Care Dr.** _____

Other providers part of your care team: _____

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

Preferred Language: _____ **Race:** _____

Pharmacy Name, Address, Phone _____

Who referred you to see us today? __Hospital or Urgent care __ Primary care doctor __Other doctor __Self Referred

What problem or reason are you being seen for? _____

MEDICAL / PAST MEDICAL HISTORY Height: _____ ft _____in Weight: _____ lbs

___ AFIB
___ Arthritis
___ Back Pain
___ Bladder Prolapse
___ Bleeding/clotting disorder
___ Cardiac Bypass
___ Colon Problems
___ Chronic Kidney Disease
___ Diabetes Mellitus
___ Difficulty Urinating
___ Deep Vein Thrombosis

___ Emphysema
___ Gastric Reflux
___ Glaucoma
___ Gout
___ Heart Attack
___ Heart Disease
___ Heart Stent
___ Hepatitis
___ Hernia
___ Hypertension

___ History of Chemo
___ History of Radiation
___ Kidney Failure
___ Kidney Stone
___ Liver Disease
___ Neuropathy
___ Obstructive Sleep Apnea
___ Pacemaker
___ Pulmonary Embolism
___ Seizure Disorder
___ Stroke/TIA

___ Thyroid Problems
___ Thyroid disease
___ Urinary Tract Infections
___ Ulcers
___ Uterine Prolapse
___ Vaginal Prolapse
___ Valve replacement

Other Medical Problems:
_____
_____

Pediatric Urologic History: _____

Urology Associates, P.C.

Patient Name: _____ _____ **DOB**: _____

PAST SURGICAL HISTORY

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

___ Other Surgeries: _____

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

Please give details and dates of past surgeries checked:
_____
_____

HEALTH MAINTENANCE

When was your last: Flu shot? _____ Pneumonia shot? _____ Colonoscopy? _____

ALLERGIES __Iodine __Latex __Shellfish ___ No known medication allergies

Medication Allergies_____

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

Drug Use: _____

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 ____ Bleeding/clotting disorder ____ Liver Disease ____ Urethral Stenosis
____ Breast Cancer ____ Diabetes ____ Osteoporosis ____ UTI's
____ Colon Cancer ____ Heart Disease ____ Polycystic Kidney Disease ____ Other:
____ Kidney Cancer ____ Hypertension ____ Thyroid
____ Pancreatic Cancer ____ Kidney Disease _____
____ Prostate Cancer ____ Lynch Syndrome
____ Testicular Cancer _____
____ Ovarian Cancer

REVIEW OF SYSTEMS No symptoms at this time____

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

Urology Associates, P.C.

Patient Name: _____ _____ **DOB**: _____

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 lose 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

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

Do you have pain associated with urination? Yes No

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

Do you have frequent bladder infections? Yes No

(For Office Use Only)

REASON FOR VISIT: Was patient referred from another doctor or facility for this visit? No Yes =(use Transition Into Care ROV)

ASSESMENT OF PLAN: __Flow Rate __Bladder Scan __UA w/ micro ___Culture __Cytology __Lupron __BCG

__Intron A __Mitomycin BMI in range? Yes / No =(CQM folder) Tobacco: Current or Former? No Yes = (CQM folder)

Urology Associates, P.C.

Patient Name: _____ _____ **DOB**: _____

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/POA/Auth.Agent Signature: _____ **Date:** _____

POA / Authorized Agent (Printed Name):_____

Urology Associates, P.C.

Patient Name: _____ _____ **DOB**: _____

CONSENT TO CONTACT / LEAVE INFORMATION

I authorize Urology Associates and associated employees to speak with or leave a message regarding my appointments, medical conditions, test results, and or billing matters with the following individuals:

___ Myself on Home: _____ Cell:_____ Work: _____

___ Spouse/Partner: ___ ALL **or** ONLY: ___ Appointments ___ Medical Conditions ___ Test Results ___ Billing Matters

Name_____ Phone: _____

___ Family/Friend: ___ ALL **or** ONLY: ___ Appointments ___ Medical Conditions ___ Test Results ___ Billing Matters

Name_____ Phone: _____

___ POA / Agent: ___ ALL **or** ONLY: ___ Appointments ___ Medical Conditions ___ Test Results ___ Billing Matters

Name_____ Phone: _____

Patient Signature: _____ **Date:** _____

POA / Authorized Agent Signature: _____ **Date:** _____

AUTHORIZATION TO COMMUNICATE BY UNENCRYPTED EMAIL

Email Communications: Information stored on our computers is encrypted; however, most popular email services (e.g.,Gmail,Hotmail,Yahoo, etc.) do not utilize encrypted email. As a result, when we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information. In addition, once the email is received by you, someone may be able to access your email account and read it. Email is a very popular and convenient way to communicate, so in a modification to the HIPAA act, the federal government provided guidance on email and HIPAA (this information is available at the U.S. Department of Health and Human Services website). The guidelines now state that as long as a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

I have read the above HIPAA notice and understand the risks of unencrypted email and do hereby give permission to Urology Associates and associated employees to send my personal health information via unencrypted email to below listed email address. I understand that this authorization is valid until revoked by me in writing and will be void without my signature below.

Email: _____

Patient Signature: _____ **Date:** _____

POA / Authorized Agent Signature: _____ **Date:** _____

POA / Authorized Agent (Printed Name):_____