



NEW PATIENT INTAKE – INFERTILITY 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:** _____

INFERTILITY INFORMATION

As a patient, you are here to see one of our providers for the diagnosis and/or treatment for some infertility issue(s). This is to inform you about what to expect from your insurance company regarding diagnosing and treatment of infertility with our providers.

Most insurance carriers have coverage policies that have exclusions for what they will and will not pay for. Infertility almost always is one of these medical conditions that your insurance carrier excludes as a covered benefit. Only in very limited circumstances, does the insurance company cover the diagnosis and treatment of infertility.

While some insurance carriers say they will cover the diagnosis for infertility, some consider a complete sperm analysis that show low to no sperm as a diagnosis. So any care you may receive after the sperm analysis may be considered as infertility and not covered. You are responsible to pay for anything that your insurance company denies as not a covered benefit.

If you have any questions regarding your coverage and what your insurance company will or will not cover, please contact your insurance carrier directly or your benefits administrator for a better explanation of your benefits. Our office has no way of knowing what your insurance company will cover, until after the claim has been processed with your insurance carrier.

I have read, understand and have agreed to the information provided.

PATIENT SIGNATURE

DATE

Urology Associates, P.C.

Patient Name: _____ DOB: _____

REASON FOR VISIT

Have you been evaluated by a urologist? No Yes – Name: _____

Have you previously conceived with another woman? No – Birth control used? Yes - How many times? _____

Have you had a semen analysis? No Yes – When & Where: _____

Do you have difficulty with erections? No Yes

Do you have retrograde ejaculation of sperm into the bladder? No Yes

Do you have a history of undescended testicles? No Yes – One Side _____, Both _____

Do you have scrotal or testicular pain? No Yes

Did you have the mumps after puberty? No Yes

Have you had prior injury to your testicles requiring hospitalization? No Yes

Do you wear Boxers _____ or Briefs _____

Have you been diagnosed with any of the following diseases? No Yes (check all that apply)

Diabetes Mellitus

Cancer

Multiple Sclerosis

Other Neurologic Problems

Prostatic Infections

Urinary Infections

High Blood Pressure

If Yes, any Medications? _____

Have you had any fever in the last three months? No Yes

Have you had a vasectomy? No Yes – Date: _____ Have you had a vasectomy reversal? No Yes – date: _____

Have you had surgery for varicocele repair? No Yes

Have you had hernia surgery? No Yes

Did you undergo any bladder or penis surgery as a child? No Yes

Check any that you are exposed to in the workplace: Prolonged Heat Radiation Harmful Chemicals None

Have you had chemotherapy for cancer? No Yes

Have you had any of the following sexually transmitted diseases? No Yes (check all that apply)

Chlamydia (date: _____)

Gonorrhea (date: _____)

Herpes (date: _____)

Syphilis (date: _____)

Genital Warts/HPV (date: _____)

HIV/AIDS (date: _____)

Hepatitis (date: _____)

Other (date: _____)

Does your wife have any infertility issues? No Yes

On a scale of 1-10 (with 10 being worst) – Estimate the level of stress you feel due to Infertility and other pressures: _____

Do you see a counselor? No Yes – For how long? _____ & How often? _____

Describe any emotional, marital, or sexual problems cause by your infertility: _____

REVIEW OF SYSTEMS (Physical Symptoms - check all that apply) No Symptoms at this time

Chills

Blurred Vision

Elevated Blood Pressure

Unusual Muscle Weakness

Fatigue

Headaches

Change in bowel habits

Numbness

Decreased Energy

Loss of Sense of Smell

Constipation

Weakness/Loss of Balance

Fever

Nasal Congestion

Diarrhea

Anxiety

Sweating

Vision Changes

Nausea

Blood Clots

Weight Gain

Swollen Glands

Vomiting

Depression

Weight Loss

Cough

Blood in Urine

Excessive Hunger/Thirst

Acne

Shortness of Breath

Frequent Infections

Thyroid Problems

Excess Hair Growth

Breast Pain

Leaking Urine

Anemia

Itching

Breast Swelling

Testicle Infections

Bleed Easily

Inflammation

Chest Pain

Easy Bruising

Urology Associates, P.C.

Patient Name: _____ DOB: _____

MEDICAL HISTORY

CURRENT VITALS: Height: _____ ft _____ in Weight: _____ lbs

PAST MEDICAL HISTORY

- | | | |
|-------------------------------------------------------|-----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Colon Problems | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Colitis (Ulcerative/Crohn's) | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Schizophrenia | |

Have you ever had a blood transfusion? No Yes: Date(s) & Reason(s) _____

PAST SURGICAL HISTORY *Include date(s) No Prior Surgeries

- | | | |
|-----------------------------------------------|--------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Brain (_____) | <input type="checkbox"/> Intestine (_____) | <input type="checkbox"/> Fallopian Tubes (_____) |
| <input type="checkbox"/> Sinus (_____) | <input type="checkbox"/> Stomach (_____) | <input type="checkbox"/> Ovaries (_____) |
| <input type="checkbox"/> Thyroid (_____) | <input type="checkbox"/> Appendix (_____) | <input type="checkbox"/> Prostate (_____) |
| <input type="checkbox"/> Lung (_____) | <input type="checkbox"/> Pancreas (_____) | <input type="checkbox"/> Testes (_____) |
| <input type="checkbox"/> Hernia (_____) | <input type="checkbox"/> Kidney (_____) | <input type="checkbox"/> Penis (_____) |
| <input type="checkbox"/> Breast (_____) | <input type="checkbox"/> Bladder (_____) | <input type="checkbox"/> Vasectomy (_____) |
| <input type="checkbox"/> Gall Bladder (_____) | <input type="checkbox"/> Uterus (_____) | <input type="checkbox"/> Back (_____) |

Did you have problems with Anesthesia? No Yes: Please describe _____

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

Other Surgeries _____

HEALTH MAINTENANCE

When was your last: Flu shot? _____ COVID-19 Vaccine? _____ Pneumonia Shot? _____ Colonoscopy? _____

ALLERGIES (Include Reactions) No known medication allergies

Medication Allergies _____

Iodine Latex Shellfish Other Food Allergies: _____

CURRENT MEDICATIONS I currently take no medications.

List Name with Dose: Include any Anti-Anxiety, Anti-Depressants, Vitamins/Supplements, Herbal or Over-the-Counter Medicines

- | | | |
|----------|---------|---------|
| 1. _____ | 4 _____ | 7 _____ |
| 2. _____ | 5 _____ | 8 _____ |
| 3. _____ | 6 _____ | 9 _____ |

SOCIAL HISTORY

Marital Status (Please circle one): Single Married Divorced Separated Widowed

Tobacco Use: Smoker: _____ packs per day / How long _____ years Former Smoker: quit _____ years Never Smoked

Alcohol Use: None Yes: Beer _____ #/wk Wine _____ #/wk Liquor _____ #/wk

How many caffeinated beverages (Coffee, Tea, Soda) do you drink a day? _____

Urology Associates, P.C.

Patient Name: _____

DOB: _____

SOCIAL HISTORY (continued)

Do you use Marijuana, cocaine or any similar drugs? No Yes: Please describe _____

Do you Exercise? No Yes: Please describe _____

Are you aware of any radiation exposure other than x-rays? No Yes: Please describe _____

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

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

- | | | |
|------------------------------------------------|---------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Heart Defect from Birth | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Other Cancer |
| <input type="checkbox"/> Bloom Syndrome | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Other Chromosome defects |
| <input type="checkbox"/> Bone/Skeletal Defects | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Polycystic Kidney Disease |
| <input type="checkbox"/> Canavan Disease | <input type="checkbox"/> Infertility | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Kidney Cancer | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Dwarfism | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tay-Sachs Disease |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Marfan Syndrome | <input type="checkbox"/> Testicular Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Neural Tube Defects | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Familial Dysautonomia | <input type="checkbox"/> Neurologic (brain/spine) | <input type="checkbox"/> Urethral Stenosis |
| <input type="checkbox"/> Gaucher Disease | <input type="checkbox"/> Niemann-Pick Disease | <input type="checkbox"/> UTI's |

WHAT IS YOUR ANCESTRY?

- African-American
- Ashkenazi Jewish
- Cajun / French Canadian
- Southern European
- American-Indian/Native American
- Asian-American
- Hispanic / Caribbean
- Caucasian
- Eastern European
- Northern European
- Other (specify) _____

LIVING FAMILY MEMBERS? (Please indicate Cause of death and Age at death)

- | | | |
|----------------------|------------------------------|------------------------------------|
| Mother | <input type="checkbox"/> Yes | <input type="checkbox"/> No: _____ |
| Father | <input type="checkbox"/> Yes | <input type="checkbox"/> No: _____ |
| Sister(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No: _____ |
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No: _____ |
| Brother(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No: _____ |
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No: _____ |
| Maternal Grandmother | <input type="checkbox"/> Yes | <input type="checkbox"/> No: _____ |
| Maternal Grandfather | <input type="checkbox"/> Yes | <input type="checkbox"/> No: _____ |
| Paternal Grandmother | <input type="checkbox"/> Yes | <input type="checkbox"/> No: _____ |
| Paternal Grandfather | <input type="checkbox"/> Yes | <input type="checkbox"/> No: _____ |

(Office Use Only)

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

ASSESSMENT OF PLAN: BMI in range? Yes / No =(CQM folder) Tobacco: Current or Former? No Yes = (CQM folder)

UA w/ micro Culture

PHYSICIAN REVIEW: I confirm that I have reviewed the above information provided in this form.

PHYSICIAN'S SIGNATURE

DATE

Urology Associates, P.C.

Patient Name: _____

DOB: _____

HIPAA NOTICE ACKNOWLEDGEMENT

FINANCIAL SERVICE AGREEMENT

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. *** **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). We will only communicate via email using our secure email system.

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.

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: _____