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: _____

Pharmacy Name, Address, Phone: _____

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 a 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, martial, or sexual problems cause by your infertility: _____

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

__ Chills
__ Fatigue
__ Decreased Energy
__ Fever
__ Sweating
__ Weight Gain
__ Weight Loss
__ Acne
__ Excess Hair Growth
__ Itching
__ Inflammation
__ Blurred Vision
__ Headaches
__ Loss of Sense of Smell
__ Nasal Congestion
__ Vision Changes
__ Swollen Glands
__ Cough
__ Shortness of Breath
__ Breast Pain
__ Breast Swelling
__ Chest Pain
__ Elevated Blood Pressure
__ Change in bowel habits
__ Constipation
__ Diarrhea
__ Nausea
__ Vomiting
__ Blood in Urine
__ Frequent Infections
__ Leaking Urine
__ Testicle Infections
__ Easy Bruising
__ Unusual Muscle Weakness
__ Numbness
__ Weakness/Loss of Balance
__ Anxiety
__ Blood Clots
__ Depression
__ Excessive Hunger/Thirst
__ Thyroid Problems
__ Anemia
__ Bleed Easily

Urology Associates, P.C.

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

MEDICAL HISTORY

CURRENT VITALS: **Height: _____ ft _____in** **Weight: _____ lbs**

PAST MEDICAL HISTORY

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

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

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

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

Did you have problems with Anethesia? ___ 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

____ Birth Defects
____ Bladder Cancer
____ Blood Clots
____ Bloom Syndrome
____ Bone/Skeletal Defects
____ Canavan Disease
____ Colon Cancer
____ Cystic Fibrosis
____ Dwarfism
____ Developmental Delay
____ Diabetes
____ Down Syndrome
____ Familial Dysautonomia
____ Gaucher Disease
____ Heart Defect from Birth
____ Heart Disease
____ Hemochromatosis
____ Hemophelia
____ Hypertension
____ Infertility
____ Kidney Cancer
____ Kidney Disease
____ Liver Disease
____ Marfan Syndrome
____ Muscular Dystrophy
____ Neural Tube Defects
____ Neurologic (brain/spine)
____ Niemann-Pick Disease
____ Obesity
____ Osteoporosis
____ Other Cancer
____ Other Chromosome defects
____ Polycystic Kidney Disease
____ Prostate Cancer
____ Psychiatric Problems
____ Sickle Cell Anemia
____ Tay-Sachs Disease
____ Testicular Cancer
____ Thyroid
____ Tuberculosis
____ Urethral Stenosis
____ 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	__ Yes	__ No: _____
Father	__ Yes	__ No:_____
Sister(s)	__ Yes	__ No:_____
	__ Yes	__ No:_____
	__ Yes	__ No:_____
Brother(s)	__ Yes	__ No:_____
	__ Yes	__ No:_____
	__ Yes	__ No:_____
Maternal Grandmother	__ Yes	__ No:_____
Maternal Grandfather	__ Yes	__ No:_____
Paternal Grandmother	__ Yes	__ No:_____
Paternal Grandfather	__ Yes	__ 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)

ASSESEMENT 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

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.

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:** _____