GEORGIA UROLOGY, P.A.

It is our desire to make your first visit to our office smooth and efficient. To do this, we ask that you actively participate in your care and have outlined a few important requests.

• We no longer use paper charts; all information in your medical record is entered electronically. Therefore, we ask that you either:

- **❖ <u>COMPLETE</u> the NextMD forms sent to you via EMAIL and follow the instructions to transmit them to us**
  - **OR**
- **❖ Return your <u>COMPLETED</u> paperwork at least 2 to 3 days before your appointment.**

This allows us to electronically create and review your medical record before your arrival.

• If you have been referred to our practice for an elevated PSA, please bring PSA TEST results with you to your appointment. This information is crucial to your care.

• Please bring X-RAY FILMS, CD IMAGE DISCS, AND ANY REPORTS about any radiology testing you may have had. We do not want to duplicate the same tests or delay your care.

• Our doctors specialize in urology, which deals with issues concerning the urinary bladder, kidneys, prostate, and other urinary concerns. The first step in detection of a urinary issue is testing of a urine specimen. PLEASE BE PREPARED TO LEAVE A SPECIMEN AT EACH APPOINTMENT.

Thank you for your cooperation. We look forward to meeting with you!

Georgia Urology, P.A.

PATIENT REGISTRATION FORM

Date: _____

Patient's Full Name : _____
Last **First** **Middle**

Birthdate: ____/____/_____ Age:_____ Sex: _____

Address: _____
Street City State Zip Code

Home Phone: (_____)-_____-_____ Work Phone: (_____)-_____-_____ Cell: (_____)-_____-_____

Marital Status: _____ Spouse's Name: _____

Person Responsible for Bill: _____ Relationship to Patient: _____

Address (if different from above): _____
Street City State Zip Code

Primary Care Physician: _____ Phone: (_____)-_____-_____

Referring Physician: _____ Phone: (_____)-_____-_____

Pharmacy: _____ Phone: (_____)-_____-_____

Patient's Employer: _____

Employer's Address: _____

Emergency Contact: _____ Phone: (____)-_____-_____

Address: _____
Street City State Zip Code

Primary Insurance Company: _____

ID Number: _____Group Number: _____ Specialist Co-Pay:

Subscriber's Name: _____ Birthdate: ___/___/____

Relationship to Patient: _____

Subscriber's Employer: _____ Phone: (____)-____-_____

Employer's Address: _____
Street City State Zip Code

Secondary Insurance Company: _____

ID Number:_____ Group Number: _____ Specialist Co-Pay:

Subscriber's Name: _____ Birthdate: ____/____/_____

Relationship to Patient: _____

Subscriber's Employer: _____ Phone: (____)-____-_____

Employer's Address: _____
Street City State Zip Code

Payment is **REQUIRED** at the time of service and is the responsibility of the patient. Services **WILL NOT** be rendered to patients without valid referrals.

I authorize Georgia Urology to perform routine medical evaluations and diagnostic procedures to assist in the diagnosis and treatment of my health problem. I also authorize Georgia Urology to release pertinent medical information to my primary care physician. Georgia Urology will abide by all HIPAA regulations regarding privacy and confidentiality.

Patient's Signature: _____ Date: _____/_____/_____

GEORGIA UROLOGY, P.A. – ACKNOWLEDGEMENT & AUTHORIZATION

PLEASE READ CAREFULLY: All charges or co-payments, if applicable, are due at the time of services. The patient is responsible for all fees, regardless of insurance coverage unless the services are for properly authorized workmen's compensation or for services covered under a contractual agreement between this Medical Practice and your insurance carrier. I understand that I need to provide, where needed, referrals from my Primary Care Physician. Furthermore, I understand that I need to notify Georgia Urology, P.A. of tests or other treatments that may not be covered by my insurance policy. I realize that I am responsible for fees that are not covered by my insurance carrier. If hospitalization is indicated, the patient is responsible for ensuring Georgia Urology, P.A. is informed of the necessary pre-certification requirements.

ASSIGNMENT OF BENEFITS: I hereby assign payment of medical benefits, as may be payable to me, to Georgia Urology, P.A. for any benefits due to me for medical or surgical care, by reason of such treatment rendered to me or the patient/insured.

HIPAA COMPLIANCE NOTICE: I hereby acknowledge that I have read the GEORGIA UROLOGY, P.A. –NOTICE OF PRIVACY POLICIES that describes how information about me may be used and disclosed and how I may obtain access to this information. Furthermore, I acknowledge that I understand these policies and have received a personal copy of this information for my records. Copies are available at any of our offices. GEORGIA UROLOGY, P.A. will abide by all HIPAA regulations regarding privacy and confidentiality as outlined in our NOTICE OF PRIVACY POLICIES.

AUTHORIZATION TO RELEASE LAB AND DIAGNOSTIC TEST RESULTS: I understand that GEORGIA UROLOGY's policy is to notify patients of any abnormal labs or diagnostic test results. We will notify you as soon as possible. I indicated below which results may be released and to whom that information may be released. (You may choose more than one option).

_____ Give my results to me personally. My daytime phone number is (____)-_____-_____. (If you are not available to speak to us, we will leave a message to call our office).

_____ If my results are benign (or within normal limits), you may leave my results on my answering machine at (check all that apply):

_____ Home (telephone number) (____)-____-_____

_____ Work (telephone number) (____)-____-_____

_____ Cell (telephone number) (____)-____-_____

_____ If you cannot reach me personally, I authorize Georgia Urology, P.A. to release my results to another person specifically:

Name: _____

Relationship: _____

Daytime Phone Number: (____)-____-_____

AUTHORIZATION TO RELEASE INFORMATION: I authorize Georgia Urology, P.A. to release all information necessary to secure payment, transmit and process claims electronically or through any other reasonable and customary means, including, but not limited to Medicare.

CONSENT FOR TREATMENT: I voluntarily consent to my treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physician. I have read this consent, and I am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to me concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND VOLUNTARILY AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

_____ _____ _____/_____/_____

Patient's Name (PRINT) **Patient's Signature** **Date**

GEORGIA UROLOGY, P.A.
ADMISSION HISTORY

Name _____ **Date of birth** _____

Today's date _____

What is the name of the doctor who referred you to Georgia Urology? _____

For your convenience, Georgia Urology P.A. may send prescriptions electronically to participating pharmacies.
WHAT IS THE NAME, STREET ADDRESS AND PHONE NUMBER OF YOUR PHARMACY?

NAME _____ **PHONE NO.** _____

ADDRESS_____

_____

_____

Do you take prescription blood thinners?	☐ **yes**	☐ **no**
Do you take aspirin or anti-inflammatory medicines every day?	☐ **yes**	☐ **no**
Do you have any heart valve problems?	☐ **yes**	☐ **no**
Have you had a joint or heart valve replacment?	☐ **yes**	☐ **no**
Have you been told by a doctor or dentist to take antibiotics before you have your teeth cleaned or dental work done?	☐ **yes**	☐ **no**
Are you allergic to latex?	☐ **yes**	☐ **no**
Are you allergic to intravenous contrast (dye)?	☐ **yes**	☐ **no**

What is (are) the reason(s) for your visit today? _____

_____

PLEASE LIST YOUR MEDICATION ALLERGIES	**REACTION**	☐ **NO ALLERGIES THAT I KNOW OF**
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Other allergies _____

_____

PLEASE LIST YOUR MEDICATIONS, <u>PRESCRIPTION, OVER-THE-COUNTER, AND HERBAL</u>	☐ **I TAKE NO MEDICATIONS**
For each medication, please tell us the dose and how often you take it	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE TELL US ABOUT YOUR MEDICAL HISTORY	☐ **NO SIGNIFICANT MEDICAL HISTORY**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

GEORGIA UROLOGY, P.A.
ADMISSION HISTORY

Name _____ **Date of Birth** _____

Today's date _____

PLEASE TELL US ABOUT YOUR SURGICAL HISTORY ☐ **NO SURGICAL HISTORY**

Surgery	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

WOMEN PLEASE COMPLETE THE FOLLOWING

Number of pregnancies _____ **Number of Cesarian sections** _____

Number of vaginal deliveries _____ **Are you currently pregnant?** ☐ **Yes** ☐ **No**

Date of last menstrual period_____

EVERYONE PLEASE COMPLETE THE FOLLOWING

FAMILY HISTORY **Please check all that apply ABOUT BLOOD RELATIVES ONLY**

☐ Blood disease
☐ BPH (Prostate enlargement)
☐ Cancer Type 1._____ 2. _____
Relation 1._____ 2. _____
☐ Cerebrovascular accident (stroke)
☐ Coronary artery disease
☐ Diabetes
☐ Eczema
☐ Gout
☐ Hearing impairment
☐ Hyperlipidemia
☐ Hypertension (high blood pressure)
☐ Inflammatory bowel disease
☐ Migraines
☐ Renal failure
☐ Seizure disorder
☐ Thyroid disorder
☐ Urinary tract infections
☐ Urolithiasis (urinary tract stones)

Other: _____
_____

SOCIAL HISTORY

Current marital status ☐ S ☐ M ☐ W ☐ D
Occupation _____

Tobacco ☐ Yes ☐ No ☐ Former
☐ Cigarettes ☐ Pipe
☐ Cigar ☐ Smokeless
☐ Chewing

Packs/day _____
How many years? _____
Tried to quit? ☐ Yes ☐ No
Year you quit _____
Passive smoke exposure? ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No
☐ Beer ☐ Wine ☐ Liquor
☐ Daily ☐ Weekly ☐ Monthly ☐ Socially ☐ Rarely
Amount: _____
Last drink:_____

Caffeine ☐ Yes ☐ No Caffeine per day_____
☐ Chocolate ☐ Tablets
☐ Coffee
☐ Soda
☐ Tea

GEORGIA UROLOGY, P.A.
REVIEW OF SYSTEMS

NAME_____ **DATE OF BIRTH**_____

DATE _____ **PLEASE CHECK ALL THAT APPLY TODAY** ☐**NONE**

CONSTITUTIONAL
- □ Activity change
- □ Decreased appetite
- □ Fatigue
- □ Fever
- □ Insomnia
- □ Irritability
- □ Malaise
- □ Night sweats
- □ Recent weight gain
- □ Recent weight loss

HEENT
- □ Headaches
- □ Vision loss
- □ Hearing loss
- □ Tinnitus
- □ Ear infections
- □ Vertigo
- □ Nosebleeds (epistaxis)
- □ Sinus infections
- □ Difficulty swallowing
- □ Sore throats

RESPIRATORY
- □ Pain during breathing
- □ Cough
- □ Frequent upper respiratory infections
- □ Bloody sputum (hemoptysis)
- □ Known TB exposure
- □ Snoring
- □ Wheezing

CARDIOVASCULAR
- □ Chest pain (cardiac)
- □ Shortness of breath(dyspnea)
- □ Lower leg swelling (edema)
- □ Shortness of breath at night (nocturnal dyspnea)
- □ Palpitations
- □ Fainting spells (syncope)

VASCULAR
- □ Leg cramping (claudication)
- □ Swelling (edema)
- □ Pain
- □ Leg ulcer
- □ Varicose veins
- □ Blood clots (thrombophlebitis)

GASTROINTESTINAL
- □ Abdominal pain
- □ Change in bowel habits
- □ Blood in stool
- □ Indigestion/Heartburn
- □ Jaundice
- □ Nausea
- □ Reflux

URINARY (GENITOURINARY)
- □ Back pain
- □ Change in urine color
- □ Cloudy urine
- □ Decreased stream
- □ Painful urination (dysuria)
- □ Flank pain
- □ Frequency
- □ Groin mass
- □ Blood in urine (hematuria)
- □ Hesitancy
- □ Incontinence
- □ Low urine output
- □ Get up at night to urinate (nocturia)
- □ Passing stone(s)
- □ Excessive urination (polyuria)
- □ Urgency

REPRODUCTIVE MALE
- □ Not applicable
- □ Penile discharge
- □ Blood in ejaculate (hematospermia)
- □ Scrotum/testicular pain
- □ Scrotum/testicular mass
- □ History of hydrocele
- □ Genital herpes
- □ Infertility
- □ Decreased libido
- □ Erection problems

REPRODUCTIVE FEMALE
- □ Not applicable
- □ Pre-menopausal
- □ Peri-menopausal
- □ Menopausal
  Date of last menses
  _____
- □ Hormone replacement
- □ Uterine fibroids
- □ History of abnormal PAP
- □ Ovarian cyst(s)
- □ Unusual vaginal discharge

METABOLIC/ENDOCRINE
- □ Cold/heat intolerance
- □ Excessive perspiration
- □ Goiter
- □ Infertility
- □ Low blood sugar (hypoglycemia)
- □ Excessive thirst (polydipsia)
- □ Excessive hunger (polyphagia)
- □ Excessive urination (polyuria)

NEUROLOGIC/PSYCHIATRIC
- □ Altered ability to speak (aphasia)
- □ Focal weakness
- □ Gait disturbance
- □ Loss of coordination
- □ Light-headed/dizziness
- □ Loss of consciousness/fainting
- □ Memory loss
- □ Numbness/tingling (paresthesias)
- □ Seizures
- □ Tremors
- □ Emotional disturbance

SKIN (DERMATOLOGIC)
- □ Contact allergies
- □ Itching (pruritis)
- □ Rash
- □ Light sensitivity (photosensitivity)
- □ Skin lesion/open area(s)

MUSCULOSKELETAL
- □ Back pain
- □ Bone/joint pain or swelling
- □ Muscle pain (myalgias)
- □ Rheumatologic issues
- □ Weakness

BLOOD FORMING(HEMATOLOGIC)
- □ Easy brusing
- □ Easy bleeding
- □ Blood clot(s) (thromboemboli)
- □ Low blood count(s) (cytopenias)
- □ Swollen glands(lymphadenopathy)

IMMUNE SYSTEM
- □ Asthma
- □ Contact dermatitis
- □ Food allergies
- □ "Bee" sting allergies
- □ Environmental allergies