ADULT PATIENT REGISTRATION FORM UROLOGIC CONSULTANTS, P.C.

Please complete all boxes!

PATIENT INFORMATION		
Last Name	First Name	MI
Social Security # *(required for identity purposes)*	Address	Apt#/Ste/Lot/2nd line
City	State	Zip
Home Phone	Work Phone - Employer	Cell Phone
Date of Birth	Race *(for statistical use only)*	Patient's Sex
Are you married? ☐ Yes ☐ No	Spouse's Name	
Do you have a primary doctor? ☐ Yes ☐ No	If yes, First and Last Name of primary doctor: Dr.	
Did this doctor refer you? ☐ Yes ☐ No	If no, First and Last Name of referring doctor: Dr.	
E-Mail Address:	Emergency Contact – Name / Phone Number	

INSURANCE INFORMATION		
Primary Insurance Company	Contract/Enrollee ID Number	
Subscriber's First and Last Name	Date of Birth	Group Number
What is the patient's relationship to the subscriber?	Employer	
Copay -OR- Secondary Insurance Company	Contract/Enrollee ID Number	
Subscriber's First and Last Name	Date of Birth	Group Number
What is the patient's relationship to the subscriber?	Employer	
Tertiary Insurance Company	Contract/Enrollee ID Number	
Subscriber's First and Last Name	Date of Birth	Group Number
What is the patient's relationship to the subscriber?	Employer	

AUTOMOBILE & WORKERS COMPENSATION CLAIMS			
Carrier's Name	Claim Number	Injury Date	
Adjuster's Name	Phone	Ext.	
Address	City	State	Zip

Patient Financial Policy

In order to promote understanding between our patients and the practice, we have implemented the following financial policy. If you have questions about the policy, please ask to speak with someone in the billing department. We are committed to providing the best possible care and service to you and your complete understanding of your financial responsibilities are a key element in providing that service. If you have questions about whether or not we participate with your insurance, please contact our office prior to your appointment. For questions about your insurance coverage, please contact your insurance company prior to your appointment. **It is always best to ask questions about your insurance coverage prior to having services performed.**

For all services rendered to minor patients, we will hold the parent or guardian responsible for expenses incurred.

Often we will perform surgical procedures and lab work that will require an outside laboratory for processing. We will bill your insurance company for the interpretation of this and a separate statement will be sent to you for any amount not paid by your insurance company.

Patients With Insurances We Participate with:

- Insurance companies require us to collect your co-pay at the time of service. Please be prepared to meet your insurance co-pay requirements at the time of service, or we will need to reschedule your appointment. We accept Cash, Check, Money Order, Care Credit, Visa, MasterCard, Discover and American Express.
- A copy of your current insurance card must be provided at each visit in order to file a claim to your insurance company.
- You will be responsible for any coinsurance or deductibles that your insurance requires.
- Your insurance policy is a contract between you and your insurance company in which the doctor is not involved.
- We will file an insurance claim with your insurance company if you provide us with your current insurance card at your visit.
- Please note: Because a service "is covered" by insurance, does not necessarily mean that your insurance company will pay for the service. Many insurance policies have deductibles that need to be met before they will pay for services. If you are unsure if you have such a policy, please contact your insurance company prior to your visit.
- If you fail to notify us of an insurance change, you will be fully responsible for any amount not paid by your insurance company.
- If you are insured by a plan that requires services to be authorized by your Primary Care Provider, you will be responsible for obtaining the authorization prior to your appointment. Should you request medical treatment from our practice without authorization from your Primary Care Provider, you will be responsible for payment at the time of service.

Patients With Insurances We Do Not Participate with:

- If you have received out-of-network authorization for services at our practice, it is your responsibility to obtain any out-of-network authorization that is needed from your insurance company. If authorization is not received prior to services, you will be required to reschedule your appointment.
- A copy of your current Insurance card must be provided at each visit in order to file a claim to your insurance company.

Self-Pay Patients:

- I understand that payment is due, in full at the time of my appointment. We accept Cash, Check, Money Order, Care Credit, Visa, MasterCard, Discover and American Express.
- Urologic Consultants participates with a medical credit card plan called, "Care Credit". Please ask to speak with our billing department for more information about the payment plan options through Care Credit.

Other:

- I authorize payment of medical benefits by the insured directly to Urologic Consultants, P.C. I also request payment of government benefits directly to the party who accepts assignment.
- I understand that there will be a $25.00 fee for all returned checks.
- I also understand, according to the State of Michigan, Department of Health, Act 488 of 1988, that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from myself, an HIV and Hepatitis-B (BBV blood test) will be performed.
- **NO SHOW VISIT POLICY:** Patients will be subject to a **$50.00 charge** if they don't show for their appointment and/or procedure. This also applies to cancellations made with less than 24-hours' notice. *See directions page to read full policy.*

PATIENT'S SIGNATURE: _____ DATE: _____

Print Name: _____

UROLOGIC CONSULTANTS, P.C.
PRELIMINARY PATIENT QUESTIONNAIRE FOR ADULTS

PATIENT'S NAME:_____ BIRTHDATE:_____ TODAY'S DATE:_____

What is the reason for your visit? _____

Have any other family members been seen at Urologic Consultants? ❑ Yes ❑ No

If yes, please list name and relationship _____

PAST MEDICAL HISTORY

Are you allergic to any medications? ☐ Yes ☐ No List: _____

Are you taking any medications? ☐ Yes ☐ No List: _____

_____

What illnesses do you have? (i.e.- diabetes, high blood pressure, heart disease, emphysema, etc.) _____

_____

What hospitalizations have you had? _____

What operations have you had? _____

FAMILY HISTORY/SOCIAL HISTORY			Comments/Family Member Relationship
Family history of cancer	☐ Yes	☐ No	_____
Family history of bladder cancer	☐ Yes	☐ No	_____
Family history of cancer of prostate	☐ Yes	☐ No	_____
Family history of kidney disease	☐ Yes	☐ No	_____
Family history of kidney stones	☐ Yes	☐ No	_____
Family history of bleeding problems	☐ Yes	☐ No	_____
Is your Mother living?	☐ Yes	☐ No	_____
Is your Father living?	☐ Yes	☐ No	_____

Do you currently smoke? ☐ Yes ☐ No

_____ cigarettes/cigars/pipe per day _____

Did you quit smoking? ☐ Yes ☐ No

If Yes, when did you quit_____ _____

Do you use alcohol? ☐ Yes ☐ No

If yes, how many drinks _____ per ☐ Day ☐ Week ☐ Month ☐ Year

How many years of education completed? _____

Patient's Signature_____ Date_____

REVIEW OF SYSTEMS

PATIENT'S NAME:_____ **BIRTHDATE:**_____ **TODAY'S DATE:**_____

Current Weight: _____ Current Height:_____

Do you now or have you ever had **any problems** related to the following?

Constitutional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Other_____		

Eyes

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Other_____		

Allergic/Immunologic

Hay fever	☐ Yes	☐ No
Drug allergies	☐ Yes	☐ No
Other_____		

Neurological

Tremors	☐ Yes	☐ No
Dizzy spells	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No
Other_____		

Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot/cold	☐ Yes	☐ No
Tired/sluggish	☐ Yes	☐ No
Other_____		

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No

Cardiovascular

Chest pain	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Other_____		

Integumentary

Skin rash	☐ Yes	☐ No
Boils	☐ Yes	☐ No
Persistent itch	☐ Yes	☐ No
Other_____		

Musculoskeletal

Joint pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Other_____		

Ear/Nose/Throat/Mouth

Ear infection	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No

Genitourinary

Urine retention	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Urinary frequency	☐ Yes	☐ No
Other_____		

Respiratory

Wheezing	☐ Yes	☐ No
Frequent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Other_____		

Hematologic/Lymphatic

Swollen glands	☐ Yes	☐ No
Blood clotting problem	☐ Yes	☐ No
Other_____		

Psychological

Are you feeling generally satisfied with your life? ☐ Yes ☐ No

Do you feel severely depressed? ☐ Yes ☐ No

Have you considered suicide? ☐ Yes ☐ No

Patient's Signature_____ Date_____

Physician's Signature_____ Date_____

UROLOGIC CONSULTANTS, P.C.
HIPAA PRIVACY

Patient Name – MRN#:

NOTICE OF PRIVACY PRACTICES

☐ The Notice of Privacy Practices was explained to me and I understand that a copy of this is available upon my request.

VOICEMAIL MESSAGES

☐ I hereby give Urologic Consultants permission to leave messages on my voicemail and/or answering machine regarding my medical information.

RELEASE OF INFORMATION

☐ I hereby grant permission to Urologic Consultants, P.C. to discuss and/or release my Protected Health Information to the following individuals involved in my care

Name/Relationship: _____

Name/Relationship: _____

Name/Relationship: _____

_____

Signature **Date**

☐ Signed by Parent/Guardian (print name): _____

*For Pediatric Patients:

I/We, being biological parent(s) or legal guardian(s) of this patient give the following person(s) permission consent to bring to appointments and complete any necessary forms on my/our behalf.

Name **Relationship**

_____

_____

Recorded by: _____