

UROLOGIC CONSULTANTS, P.C.

ADULT PATIENT REGISTRATION FORM

PATIENT INFORMATION			
Last Name	First Name (Full legal name)	Middle	
Social Security #	Address	Apt#	
City	State	Zip	
Home Phone	Place of Employment and Phone Number	Cell Phone	
Date of Birth	Race <i>(for statistical use only)</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Spouse's Name		
Do you have a primary doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, First and Last Name of primary doctor:		
Did this doctor refer you? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, First and Last Name of referring doctor:		
Emergency Contact – Name/Relationship	Emergency Contact - Phone Number		
INSURANCE INFORMATION			
Primary Insurance Company		Contract Number	
Subscriber's First and Last Name	Date of Birth	SSN	
Relationship to Patient	Employer		
Secondary Insurance Company		Contract Number	
Subscriber's First and Last Name	Date of Birth	SSN	
Relationship to Patient	Employer		
Tertiary Insurance Company		Contract Number	
Subscriber's First and Last Name	Date of Birth	SSN	
Relationship to Patient	Employer		
AUTOMOBILE & WORKERS COMPENSATION CLAIMS			
Carrier's Name	Claim Number	Injury Date	
Adjuster's Name	Phone	Ext.	
Address	City	State	Zip

UROLOGIC CONSULTANTS, P.C.
ADULT AND PEDIATRIC UROLOGY

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Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance. We accept Cash, Check, Visa, MasterCard and Discover.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor; in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurance, we will refund any overpayment to you.
3. We have made prior arrangement with many insurance companies and other health plans to accept any assignment of benefits. We will bill them, but **you are required to pay a co-payment and/or deductible at the time of your visit.**
4. 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.**
5. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
6. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
7. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.
8. I 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 that a HIV and Hepatitis-B (BBV blood test will be performed).
9. 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.

PATIENT'S SIGNATURE: _____

DATE: _____

PARENT or GUARDIAN: _____

DATE: _____

UROLOGIC CONSULTANTS, P.C.

PRELIMINARY HEALTH QUESTIONNAIRE

Patient's Name _____ Date _____

REFERRING PHYSICIAN

First and Last Name _____

Address _____

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

Allergies to Medications? Yes No

List medications you CANNOT take:

Are you on any medications? Yes No

List the medications you ARE taking:

What hospitalizations have you had?

What operations have you had?

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

Are you on a special diet? Yes No

If yes, what one? _____

FAMILY HISTORY/SOCIAL HISTORY (please check one)

Comments

Family history of cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Family history of cancer of prostate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Family history of kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Family history of kidney stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Family history of bleeding problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Parents: <i>Mother alive?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<i>Father alive?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

TELL US ABOUT YOU

<i>Are you married?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>If yes, spouses name?</i> _____
<i>Are you employed?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>If yes, type of work?</i> _____
<i>Do you smoke?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>Do you use alcohol?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

How many years of education have you completed? _____

Current weight _____ Current height _____

Patient's Signature _____ Date _____

REVIEW OF SYSTEMS

Patient's Name _____

Date _____

Do you now OR have you ever had any problems related to the following? (please check one)

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 _____

Psychologic

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 _____