**ADULT PATIENT REGISTRATION FORM**

**Please complete all boxes! Pt #** **Acct\_Account -** **PP\_LastName**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 | | Patient’s Contract Number / Group Number | | | | |
| Subscriber’s First and Last Name | | Date of Birth | | Subscriber Number/Group | | |
| What is the patient’s relationship to the subscriber? | | Employer | | | | |
| Copay -OR- Secondary Insurance Company | | Contract Number | | | | |
| Subscriber’s First and Last Name | | Date of Birth | | Subscriber Number/Group | | |
| What is the patient’s relationship to the subscriber? | | Employer | | | | |
| Tertiary Insurance Company | | Patient’s Contract Number / Group Number | | | | |
| Subscriber’s First and Last Name | | Date of Birth | | Subscriber Number/Group | | |
| 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 |

Pt # Acct\_Account

**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.

PATIENT’S SIGNATURE: DATE:

Pt # Acct\_Account

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

Pt #«Pat\_Patient\_No»

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 Integumentary

Fever 🞏 Yes 🞏 No Skin rash 🞏 Yes 🞏 No

Chills 🞏 Yes 🞏 No Boils 🞏 Yes 🞏 No

Headache 🞏 Yes 🞏 No Persistent itch 🞏 Yes 🞏 No

Other Other

# Eyes Musculoskeletal

Blurred vision 🞏 Yes 🞏 No Joint pain 🞏 Yes 🞏 No

Double vision 🞏 Yes 🞏 No Neck pain 🞏 Yes 🞏 No

Pain 🞏 Yes 🞏 No Back pain 🞏 Yes 🞏 No

Other Other

# Allergic/Immunologic Ear/Nose/Throat/Mouth

Hay fever 🞏 Yes 🞏 No Ear infection 🞏 Yes 🞏 No

Drug allergies 🞏 Yes 🞏 No Sore throat 🞏 Yes 🞏 No

Other Sinus problems 🞏 Yes 🞏 No

# Neurological Genitourinary

Tremors 🞏 Yes 🞏 No Urine retention 🞏 Yes 🞏 No

Dizzy spells 🞏 Yes 🞏 No Painful urination 🞏 Yes 🞏 No

Numbness/tingling 🞏 Yes 🞏 No Urinary frequency 🞏 Yes 🞏 No

Other Other

# Endocrine Respiratory

Excessive thirst 🞏 Yes 🞏 No Wheezing 🞏 Yes 🞏 No

Too hot/cold 🞏 Yes 🞏 No Frequent cough 🞏 Yes 🞏 No

Tired/sluggish 🞏 Yes 🞏 No Shortness of breath 🞏 Yes 🞏 No

Other Other

# Gastrointestinal Hematologic/Lymphatic

Abdominal pain 🞏 Yes 🞏 No Swollen glands 🞏 Yes 🞏 No

Nausea/vomiting 🞏 Yes 🞏 No Blood clotting problem 🞏 Yes 🞏 No

Indigestion/heartburn 🞏 Yes 🞏 No Other

# Cardiovascular Psychological

Chest pain 🞏 Yes 🞏 No *Are you feeling generally satisfied with your life?*

Varicose veins 🞏 Yes 🞏 No 🞏 Yes 🞏 No

High blood pressure 🞏 Yes 🞏 No *Do you feel severely depressed?*

Other 🞏 Yes 🞏 No

*Have you considered suicide?*

🞏 Yes 🞏 No

Patient’s Signature Date

Physician’s Signature Date

**UROLOGIC CONSULTANTS, P.C.**

#### Patient Acknowledgement

I hereby acknowledge that I have reviewed **Urologic Consultants Notice of Privacy Practices**. I further understand that a copy of the Notice of Privacy Practices is available to me upon my request.

Patient’s Name: Acct\_FullName #Acct\_Account

Signature (Parent if Minor): **X**

##### RELEASE OF INFORMATION

🞎 Check box if we may leave messages on your answering machine.

I hereby grant permission to Urologic Consultants, P.C. to release my protected health information to the following family members and/or friends who may be involved in my care:

**🗦 PLEASE PRINT 🗧**

* Spouse (Name)
* Other (Name/Relation)
* Other (Name/Relation)

***NOTE: Information will automatically be released to parents of patients who are under the age of 18 unless otherwise indicated. Please list names below of parent(s) who should NOT receive protected information. You must also present legal documentation of non-rights for any persons listed.***

Name(s)/Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recorded by:

**(FOR OFFICE USE ONLY)**

# Accounting of Disclosures: *(for purposes other than treatment, payment and health care operations)*

## Date Requesting Party Information Provided Purpose

Appt\_Date / Appt\_Resource