CAPITAL HEALTH UROLOGY SPECIALISTS

Name: _____ DOB: _____

Reason for appointment: _____

Referring Physician: _____ Primary Care Physician: _____

Have you seen a urologist before? Y / N If so, who? _____

Symptoms currently or in the last year:

General:

- ☐ Chills
- ☐ Depression
- ☐ Anxiety
- ☐ Dizziness/ fainting
- ☐ Tiredness
- ☐ Fever
- ☐ Headache
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats
- ☐ Chills
- ☐ Swollen glands

Musculoskeletal:

- ☐ Joint pain
- ☐ Back pain
- ☐ Neck pain
- ☐ Arthritis

Cardiovascular:

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Heart murmur
- ☐ Varicose veins

Gastrointestinal:

- ☐ Poor appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Abdominal pains
- ☐ Vomiting

Ear/Nose/Throat:

- ☐ Blurred vision
- ☐ Double vision
- ☐ Persistent cough
- ☐ Shortness of breath
- ☐ Hoarseness
- ☐ Allergies (seasonal)
- ☐ Earaches/ infections
- ☐ Loss of hearing

Skin:

- ☐ Bruising
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Sores that won't heal

Men ONLY:

- ☐ Erection difficulty
- ☐ Blood in semen
- ☐ Lump in testicles
- ☐ Lump in breast
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Prostatitis
- ☐ Decreased sex drive
- ☐ # of children: _____
- ☐ Other: _____

Women ONLY:

- ☐ Abnormal pap smear
- ☐ Bleed between periods
- ☐ Breast lump
- ☐ Menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse

Women ONLY:

- ☐ Vaginal discharge
- ☐ Leaking urine when coughing
- ☐ Leaking urine anytime
- ☐ Other: _____

Gynecologist: _____

Last period: _____

Last pap smear: _____

Last GYN exam: _____

Last mammogram:

_____

Are you pregnant? Y / N

# of pregnancies: _____

# of children: _____

# of abortions or miscarriages: _____

Genito-urinary:

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Loss of bladder control
- ☐ Leaking urine
- ☐ Painful urination
- ☐ Difficult urination
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Kidney stones
- ☐ Pain in the side or back
- ☐ Bed-wetting
- ☐ Waking at night to urinate

Conditions:

- ☐ AIDS or HIV
- ☐ Alcoholism
- ☐ Bleeding disorder
- ☐ Cancer: _____
- ☐ Drug dependency/abuse
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Headaches
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Other: _____
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mumps
- ☐ Neurological disease
- ☐ Pacemaker
- ☐ Prostate problem
- ☐ Psychiatric problem
- ☐ Sexually transmitted disease
- ☐ Sickle Cell disease
- ☐ Stroke/ TIA
- ☐ Suicide attempt
- ☐ Thyroid problem
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Vaginal disease
- ☐ Vaginal infection

Medications and herbal supplements (include dosage and frequency):

Allergies to medications, foods, latex, etc:

Surgeries with date:

Do you or have you smoked tobacco?	Yes No	How much: How many years: Quit:
Do you drink alcohol?	Yes No	How much/often:
Have you ever used illicit drugs?	Yes No	When and what kind:

Family History

Mother alive / deceased Cause of death: _____ Age: _____

Father alive / deceased Cause of death: _____ Age: _____

Sister alive / deceased Cause of death: _____ Age: _____

Brother alive / deceased Cause of death: _____ Age: _____

Do you have an immediate family member who has *or* had the following?
Please check box and provide relationship

	YES	**WHO?**		**YES**	**WHO?**
Prostate cancer			Kidney disease		
Kidney cancer			Heart disease		
Bladder cancer			Kidney stones		
GYN cancer			Testes cancer		
Breast cancer			Diabetes		

Any other important things not listed? _____

Screening history

	Date		**Date**
Last flu shot		Last eye exam	
Last colon screening		Last pneumonia shot	

Do you have any cultural/religious practices that may affect your treatment? □ Yes □ No

If so, what: _____

What is your present occupation? _____

General & Financial Consent: Capital Health Medical Group

Consent for Treatment:

I consent to be treated by Capital Health Medical Group under the care of my physician and/or psychotherapist, his/her associates, partners, assistants and designees. I consent to the care which encompasses routine laboratory, diagnostic, medical/surgical, and/or psychotherapeutic treatment advisable during treatment. I agree to allow medical, psychology, social work, and nursing trainees, under the supervision and direction of a physician or other licensed provider, to observe my treatment and review my medical record. I understand no guarantees have been made to me about the outcome of this care. I acknowledge Capital Health has the authority to dispose of specimens taken for laboratory and pathology examination.

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) DATE/TIME

Financial Agreement:

I agree whether I sign as a representative of the patient or as the patient, that in consideration of the services to be rendered to me, I obligate myself to pay the account of Capital Health Medical Group in accordance with the regular rates and terms of the group. I intend to be legally bound, assume full responsibility for and agree to pay Capital Health upon presentation of the bill, all expenses and charges for such services and care. Should the account be referred to an attorney for collection, I shall reimburse Capital Health reasonable attorney's fees and collection expense.

Medicare Authorization for Information and Payment Request Release:

I agree the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to Social Security Administration or its intermediaries or carriers or to the Professional Review Organization any information needed in order to process payment for this visit or a related Medicare claim. I request that payment or authorized benefits be made on my behalf, if I am a member of a Medicare Risk Contracting Health Maintenance Organization.

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf to Capital Health Medical Group for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release any information needed to determine these benefits payable for related services.

Release of Information:

I assign benefits payable for physicians' services to the physician or provider furnishing services and authorize such physician or provider to submit a claim containing information related to my treatment, to Medicare, Medicaid or other Insurance Carrier for payment. I understand that if under Medicare Program Guidelines, as necessary, Capital Health Medical Group is required by various governmental agencies to review and release patient information. Capital Health Medical Group also cooperates with various agencies by providing statistics and medical information for research purposes. I understand and agree that Capital Health is authorized to review and release such information. I understand that these records will contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Any specimens taken from my body during treatment may be retained, preserved, used for teaching purposes, or disposed of by Capital Health Medical Group.

Consent to Release Medical Records:

I authorize the release of my medical records and information for the purpose of coordinating care and discharge planning and for the purpose of my follow-up are, this includes designated Care Giver, if elected. I understand that the information disclosed may include Specially Protected Health Information such as records of psychiatric treatment, counseling or testing, substance abuse counseling or treatment, and/or HIV/AIDS diagnosis, treatment or testing. I may revoke this authorization as it related to Specially Protected Health Information by providing written notice to Capital Health Medical Group.

Consent for Blood Test:

In the event a physician, employee, worker or student is accidentally stuck with a needle or otherwise directly exposed to my blood or body fluids, I consent to having my blood tested for Human Immunodeficiency Virus (HIV, the virus that causes Acquired Immune Deficiency Syndrome, AIDS). Such testing will allow any necessary treatment of the physician, employee, worker or student to being without delay. I further understand that if such testing is required I will receive appropriate counseling. The results of the test will be released only to those involved with the medical treatment of the exposed physician, hospital employee, worker or student or as required by law or as agreed to by me.

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) DATE/TIME

Acknowledgement of Privacy Notice: I acknowledge receipt of Capital Health Notice of Privacy Policy

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) DATE/TIME

Patient Name: _____ DOB: _____ Date: _____

Living Will:

Do you have a Living Will and Durable Power of Attorney? **YES** **NO**

If **YES**, please furnish us with a copy for your medical chart or allow us to make a copy to attach to your chart. Thank you.

If **NO**, would you like more information regarding this subject? **YES** **NO**

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., Please indicate where we can leave a message:

CIRCLE YES OR NO

HOME NUMBER ~ YES / NO _____

CELL NUMBER ~ YES / NO _____

II. I AUTHORIZE THE FOLLWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I agree _____ to the above. Date Signed: _____
(Patient Signature)

Signing this form verifies all information is correct and /or has been updated.

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Medication History & Medication Benefits Consent

I give permission for Capital Health to obtain my current Medications and Medication History from the Surescripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at Capital Health.

Patient Signature: _____ Date: _____

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call your office. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a **24 hour** advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your appointment history as a "no-show".

Missed Appointment Fees

- Patients who fail to keep an appointment will be rescheduled once upon request: **No Charge**
- After a second and subsequent missed appointment: **$25 fee billed to your account**
- Third missed appointment: **Possible discharge from our practice**

Patient Name: _____

Patient's Signature: _____ Date: _____