2529 Glenn Hendren Dr.
Suite 202
Liberty, MO 64068
816-781-8400
816-781-8263 (fax)

UROLOGY SPECIALISTS, P.C.

2700 Clay Edwards Dr.
Suite 300
North Kansas City, MO 64116
816-842-0171
816-842-3582 (fax)

Date:

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's Last name: First: Middle:			Marital status (circle one) Single / Married / Divorced / Separated / Widow		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Patient Social Security #:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Race: ❑ White ❑ Black/African American ❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian/Other Pacific Islander ❑ Unknown			Ethnicity: ❑ Not Hispanic/Latino ❑ Hispanic/Latino		
Primary Language:	**Please indicate if we may leave a message on your home or cell phone regarding: lab results, prescriptions, or any patient related information. We will leave an automated appointment reminder on the phone you designate as "Home phone."**				
Street address:	Home phone #: **OK to leave Messages Yes/No** ( )	Cell phone #: **OK to leave Messages Yes / No** ( )			
P.O. Box:	City:	State:	ZIP Code:		
Email:	Employer:	Employer phone #: Ok to leave Messages Yes / No ( )			
Referred to clinic by:	❑ Dr. _____	❑ Self Referral	Choose Clinic by:	❑ Insurance Plan	❑ Hospital ❑ Internet
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Responsible Party (If patient is a minor):		Home phone no.: ( )	Cell phone no.: ( )		

IN CASE OF EMERGENCY

Primary Contact Person:	Home phone # ( )	Work phone # ( )	Cell phone # ( )
Relationship to Patient:	**Disclose Medical Information Yes / No**	**Disclose Billing Information Yes / No**	
Secondary Contact Person:	Home phone # ( )	Work phone # ( )	Cell phone # ( )
Relationship to Patient:	**Disclose Medical Information Yes / No**	**Disclose Billing Information Yes / No**	

INSURANCE INFORMATION

Is this patient covered by insurance?	❑ Yes	❑ No	Are cards available to be scanned?	❑ Yes ❑ No
Name of Primary Insurance:				
Insured's Name:	Member ID#	Group #	Birth Date of Insured:	
Employer:	Employer address:		Employer phone #	
Patient's relationship to insured:	❑ Self ❑ Spouse	❑ Child	❑ Other	
Name of Secondary Insurance:				
Insured's Name:	Member ID#	Group #	Birth Date of Insured:	
Employer:	Employer address:		Employer phone #	
Patient's relationship to insured:	❑ Self ❑ Spouse	❑ Child	❑ Other	

PHYSICIAN INFORMATION

Name of **Primary Care Physician:**		Phone No.:
Street address:		
City:	State:	ZIP Code:
Name of **physician who ordered consultation** (Referring physician) (if different):		Phone #
Street address:		
City:	State:	ZIP Code:

PHARMACY INFORMATION

Name of **Primary Pharmacy:**	Address:	Phone #
Name of **Secondary Pharmacy**:	Address:	Phone #

COMMERCIAL AND MEDIGAP (MEDICARE SUPPLEMENTAL)INSURANCE ASSIGNMENT & RELEASE

I, the undersigned, assign directly to *UROLOGY SPECIALISTS, P.C.* all medical benefits, if any, otherwise payable to me for services rendered by my commercial or Medigap insurance as stated above.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. This authorization applies to all services until it is revoked by me or my representative.

_____ _____

Signature of Insured/Guardian *Date*

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *UROLOGY SPECIALISTS, P.C.,* for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Beneficiary *Date*

PATIENT FINANCIAL AGREEMENT AND NOTICE OF PRIVACY PRACTICES

- I, the undersigned, agree to be responsible for the balance of my account.
- Although an insurance claim (if applicable) will be filed with my insurance company by the doctor on my behalf, negotiating payments through my insurance company ultimately is my obligation.
- If my insurance requires a referral/authorization from my Primary Care Physician, I understand it is my responsibility to obtain this.
- If I have no insurance, I understand that payment will be made at the time services are rendered unless financial arrangements have been made PRIOR to the services.
- A statement will be mailed to me each month showing the total balance due from me and will be considered past due within 30 days from receipt. Items billed to my insurance will become past due if no reply is received within 45 days.
- If I am unable to make payment in full, I understand that I should call the billing department immediately at 221.6581 to make payment arrangements.
- I understand that if no payment has been received or no financial arrangements have been made on my balance after 45 days, my account may be referred for collections.
- If my account is referred for collections, I understand that I will be responsible for the balance as well as all collection costs and reasonable attorney's fees.
- I understand that I may be subject to a $25 service charge for failing to show to an appointment and for cancelling an appointment without giving a 24 hour notification.
- I understand that co-pays are due at the time of service payable by Visa, MasterCard, cash or check.
- I have been made aware that the "Notice of Privacy Practices" is displayed in the waiting area and that I may request a copy.

X_____ _____

Signature of Responsible Party Date

Patient Name: Patient Date of Birth:

REASON FOR VISIT/CHIEF COMPLAINT:

PAST MEDICAL HISTORY

LIST YOUR PRESCRIBED AND OVER-THE-COUNTER DRUGS, INCLUDING VITAMINS		
Name of Drug	Strength	Frequency Taken

ALLERGIES	
Name of Drug/Substance	Reaction

PLEASE LIST ALL PRIOR SURGERIES			
Date	Surgery	Date	Surgery

PLEASE LIST ALL PAST AND CURRENT MEDICAL CONDITIONS			
Date Diagnosed	Medical Condition	Date Diagnosed	Medical Condition

Are you required to take antibiotics with dental work?	☐ Yes	☐ No

Patient Name: Patient Date of Birth:

FAMILY HISTORY

Does anyone in your family have a history of any of the following: *(Please check all that apply and identify family member (Aunt, Uncle, Brother, Sister, Mother, Father, Grandmother, Grandfather, daughter, son, cousin, etc)* ☐***None Apply***

☐ Adrenal Cancer		☐ Kidney Stones	
☐ Alcoholism		☐ Lung Problems	
☐ Anesthesia Problems		☐ Polycystic Kidneys	
☐ Bladder Cancer		☐ Prostate Cancer	
☐ Bleeding Disorders		☐ Strokes	
☐ Diabetes		☐ Testicular Cancer	
☐ Heart Problems		☐ Thyroid Disease	
☐ High Blood Pressure		☐ Tuberculosis	
☐ Kidney Cancer		☐ Urinary Tract Infection	
☐ Kidney Disease		☐ Other Cancer (specify)	

SOCIAL HISTORY

Personal

Occupation:

Do you have a DNR (Do Not Resuscitate)?	☐ Yes	☐ No	Living Will?	☐ Yes	☐ No	Power of Attorney?	☐ Yes	☐ No
Have you ever had a blood transfusion?							☐ Yes	☐ No

Tobacco

Do you smoke?

☐ Yes - Everyday When did you start? How many packs/ day?
☐ Yes – Occasionally
☐ No - Former Smoker When did you quit? How many packs/ day? How long did you smoke?
☐ No - Never

Alcohol

Do you drink alcohol?

☐ Yes How much do you drink?
What type of alcohol?
Drinking Habit? ☐ Social ☐ Light ☐ Moderate ☐Excessive

☐ No - Not anymore When did you quit? How long did you drink? How much did you drink?

Caffeinated Drinks

How many caffeinated drinks do you have each day? _____

REVIEW OF SYSTEMS

Do you now have or have you had any of the following? ***(Please circle all that apply)***

Fever	Chills	Weight Loss	Excessive Thirst
Blurry Vision	Double Vision	Cataracts	Vision Loss
Hearing Loss	Nasal Stuffiness	Sore Throat	
Chest Pains	Swollen Ankles	Irregular Heartbeat	
Shortness of Breath	Wheezing	Chronic Cough	Productive Cough
Abdominal Pain	Nausea / Vomiting	Change in Bowels	Constipation
Incontinence	Painful Urination	Blood in Urine	Frequent UTI
Chronic Back Pain	Chronic Neck Pain	Sore Muscles	Paralysis / Weakness
Rash	Persistent Itching	Skin Cancer History	
Numbness	Tingling	Dizziness	
Swollen Glands	Abnormal Bleeding	Transfusion History	

Patient Name: Patient Date of Birth:

MALE HEALTH INVENTORY

Please answer the following questions regarding **URINARY SYMPTOMS** and **ERECTILE FUNCTION** by circling the appropriate answer below:

URINARY INVENTORY

Never	< 1 time in 5	< half the time	About half the time	> half the time	Almost always
0	1	2	3	4	5

Using the above guideline, please circle the number below that best relates to you.

1. **Incomplete Emptying**: Sensation of not emptying your bladder completely after you have finished urinating

0	1	2	3	4	5

2. **Frequency:** Urinating again < 2 hrs after urination

0	1	2	3	4	5

3. **Intermittency:** How often have you found you stopped and started again several times when you urinated?

0	1	2	3	4	5

4. Urgency: Difficulty postponing urination

0	1	2	3	4	5

5. **Weak Urinary Stream:**

0	1	2	3	4	5

6. **Straining**: Pushing or straining to begin urination

0	1	2	3	4	5

7. **Nocturia:** How many times do you get up to urinate from the time you go to bed at night until the time you get up in the morning? **(circle the # of times/night)**

0	1	2	3	4	5

SEXUAL INVENTORY

I have been using

Viagra	☐ Yes	☐ No		Cialis	☐ Yes	☐ No	
Levitra	☐ Yes	☐ No		Muse	☐ Yes	☐ No	
Vacuum Device	☐ Yes	☐ No		Penile Injection	☐ Yes	☐ No	

Please circle the number of the response that *best describes* your own situation **over the past 3 months.**

1. Rate your confidence that you could get & keep an erection

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No sexual activity	Almost never	A few times	Sometimes	Most times	Almost always
0	1	2	3	4	5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

No sexual activity	Almost never	A few times	Sometimes	Most times	Almost Always
0	1	2	3	4	5

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

No sexual activity	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
0	1	2	3	4	5

5. When you attempted sexual intercourse, how often was it satisfactory to you?

No sexual activity	Almost never	A few times	Sometimes	Most times	Almost Always
0	1	2	3	4	5

Total of 7 items above:_____ **Total of 5 items above:_____**

Have you had your prostate surgically removed for prostate cancer? ☐ Yes ☐ No If yes, date of operation: _____

If yes, do you leak any urine? ☐ Yes ☐ No If yes, how many pads per day do you wear to keep dry? _____

Patient Name: Patient Date of Birth:

FEMALE HEALTH INVENTORY		
Age at onset of menstruation:		
Have you undergone menopause?	☐ Yes	☐ No
If no, date of last menstruation:		
If no, do you have heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any frequency of urination?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
If yes, do you leak urine with coughing, sneezing, or vigorous activity?	☐ Yes	☐ No
If yes, do you leak urine due to a sudden feeling of urgency?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of your period?	☐ Yes	☐ No
Date of last pap and rectal exam?		