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Demographic Information

Name: _____ DOB: _____ Sex: **M** **F**

Primary Address: _____
(Street and Apt #) (City) (State) (Zip)

Secondary Address: _____
(Street and Apt #) (City) (State) (Zip)

Home Number: () _____ () None Cell Number: () _____

Email Address: _____ (used only for patient portal)

Patient Guardian (if applicable): _____ DOB: _____

If you are the legal guardian for this patient, please provide the supporting documentation to the Front Office.

Emergency Contact: _____ Phone Number: () _____

Relationship to Patient: _____

Primary Insurance: _____ ID#: _____

Cardholder Name and DOB (if different from the patient): _____

Secondary Insurance: _____ ID#: _____

Cardholder Name and DOB (if different from the patient): _____

PCP: _____ Referred by: _____

How did you hear about us? _____

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring healthcare provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims assessment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductible, co-insurance and copays. I understand that I am financially responsible for any charges not covered by my insurance, and if I fail to give updated, current information and the claim is denied, I will be responsible for the entire balance.

In the event your check is returned for any reason, your account will be charged \$35.00. If we determine your account should be placed with an outside collection agency, or an attorney, you will be assessed with an additional 50% of the balance due.

Patient/Guardian Signature: _____ Date: _____

Surgical History: (Please list all surgeries you have had and when they occurred)

No Surgeries

- Bladder Surgery: _____
- Kidney Surgery: _____
- Joint Replacement: _____
- Cardiovascular: _____
- Reproductive: _____

Please list all other surgeries, if not listed above:

Urologic Disease History: (Please check "YES" for all that apply)

	YES	NO		YES	NO		YES	NO
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Stones (Urolithiasis)	<input type="checkbox"/>	<input type="checkbox"/>	STD/STI	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Bladder)	<input type="checkbox"/>	<input type="checkbox"/>	Neurogenic Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Urethral Stricture	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Kidney)	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination (Dysuria)	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary Trauma	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/>
Hydronephrosis	<input type="checkbox"/>	<input type="checkbox"/>	Renal Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>
			Renal Tubular Acidosis	<input type="checkbox"/>	<input type="checkbox"/>	Vesicoureteral Reflux	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Family History: (Please check "YES" for all that apply and indicate Family Member)

	YES	NO	
Kidney Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Bladder Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Genital Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Who: _____

Allergies: (Please list any allergies and type of reaction)

No Known Drug Allergies

Allergies	Reaction

Review of Systems (Please check all POSITIVE complaints.)

No Positive Complaints

Constitutional: Chills Fever Weight loss

Cardio: Chest Pains Swollen ankles High Blood Pressure

Eyes: Blurred Vision Eye Pain Worsening Eyes

Skin: Rash Lesions Psoriasis

Allergies: Drug Food Seasonal

Musculoskeletal: Arthritis Cramps Gout

Neurological: Dizzy Headache Seizures

ENT: Sore Throat Ear Infections Sinus Problems

Endocrine: Thirst Tired Hot/Cold

Respiratory: Asthma Shortness of Breath Cough

GI: Heartburn Diarrhea Constipation

Hematologic: Anemia Easy Bleeding Swollen Glands

Kidney Disease: Renal Failure Transplant

Psychologic: Anxiety Depression Suicidal Thoughts

Other Conditions: _____

Please select the most appropriate answer to the following questions.

	Never	Rarely	Sometimes	Half the Time	Often	Always
How often do you have difficulty in postponing urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you leak urine during activities like coughing, sneezing, lifting or exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have a strong need to empty your bladder before you start to leak urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you lose (leak) urine while you are sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you lose (leak) urine when you do not want to?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many times do you urinate during the day?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5+
How many times do you get up at night to urinate?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5+
Have you received treatment for urinary incontinence (leakage) in the past?	<input type="checkbox"/> YES <input type="checkbox"/> NO					
Do you wear a form of protection for your leakage?	<input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", how many pads per day? _____					
Do you see blood in your urine?	<input type="checkbox"/> YES <input type="checkbox"/> NO					
How would you feel if you had to live with your urinary condition the way it is now, no better and no worse, for the rest of your life?	<input type="checkbox"/> Delighted <input type="checkbox"/> Pleased <input type="checkbox"/> Mostly Satisfied <input type="checkbox"/> Mixed <input type="checkbox"/> Unhappy <input type="checkbox"/> Terrible					

Please turn this page over to continue.

