CARSON UROLOGISTS - Patient Registration Form

PATIENT INFORMATION			
Patient Name	DOB	M [ ] F [ ]	
Mailing Address	City	State	Zip
Physical Address	City	State	Zip
Home # Work #	Cell #	Soc Sec # - -	
Occupation	Employer		
Email Address	Ethnicity	[ ] Married [ ] Single [ ] Divorced [ ] Widow	
Requested PHARMACY	Requested LABORATORY		
SPOUSE/PARENT/LEGAL GUARDIAN INFORMATION			
Spouse/Parent/Guardian Name	DOB:	M [ ] F [ ]	
Mailing Address	City	State	Zip
Physical Address	City	State	Zip
Home # Work #	Cell #	Employer	
PRIMARY INSURANCE INFORMATION			
Name of Insurance	Name of Policy Holder		
Insurance ID#	Group#.	Employer	
DOB of policyholder	SS# - -		
Patient relationship to policyholder Self [ ] Spouse [ ] Child [ ] Other [ ]			
SECONDARY INSURANCE INFORMATION			
Name of Insurance	Name of Policy Holder		
Insurance ID#	Group#	Employer	
DOB of policyholder	SS# - -		
Patient relationship to policyholder Self [ ] Spouse [ ] Child [ ] Other [ ]			
EMERGENCY CONTACT (Not living with you)	Name		
Relationship to you	Home#	Work#	Cell#
REFERRAL INFORMATION			
PRIMARY CARE PHYSICIAN:			
REFERRING PHYSICIAN:			
CALLS AND MESSAGES			
You can leave a message at home	Yes [ ]	No [ ]	
You can leave a message at work	Yes [ ]	No [ ]	
You can leave a message on cell	Yes [ ]	No [ ]	
You may email me at above address	Yes [ ]	No [ ]	
You may access my RX external history	Yes [ ]	No [ ]	

I Hereby consent for treatment and give authorization for payment of insurance benefits to be made directly to CARSON UROLOGISTS, and any assisting physicians for services rendered. The above information I have provided is current and accurate. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.
I agree that certain samples or specimens may be sent out for further testing and I may receive a separate bill for these services.

Date: ____________ Signature: ______________________

Updated on: ____________ Signature: ______________________

Patient History

First name: ______________________ Last name: ______________________

Today's date: ____/____/____ Date of birth: ____/____/____ Referring physician: ______________

Chief complaint – What is the main reason that brings you into the office today?

____

____

History of present illness

Location of problem: ____

On scale from 1-10, with 10 being the most severe, circle the number that best describes the problem

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem? ______________________________

Does anything make the problem worse? ______________________________

How long does the problem last? ____________________________________

Is anything else occurring at the same time? __________________________

Is the problem constant or variable? ________________________________

Does the problem interfere with your normal activities? Yes or No

If yes, please explain: ____

Past Medical and Social History – please list

All current and past medical problems:

All past surgeries:

All current medications/vitamins:

Do any illnesses or diseases run in the family? O Yes O No

Are you allergic to any medications? O Yes O No Current allergies: ______________________

Do you smoke? O Yes O No

Do you drink alcohol? O Yes O No

Signature: ______________________________________

**NOTE: You will be required to give a urine specimen

Review of Systems (please fill in a circle for yes or no for each)

First name: ____________________ Last name: ____________________

Today's date: ____/____/____ Date of birth: ____/____/____

Genitourinary

Question	
Do you rush to the bathroom when you get the urge to urinate?	O Yes O No
Do you ever wet yourself because you do not get to the bathroom in time?	O Yes O No
Do you wear pads because of wetness?	O Yes O No
If yes, how many pads do you wear per day? _____	
Do you feel you urinate more frequently than normal?	O Yes O No
Do you experience burning when you urinate?	O Yes O No
Does your urine stream stop and start while you urinate?	O Yes O No
Do you feel you have a weak urinary stream?	O Yes O No
Do you ever get the sensation that you do not empty the bladder completely?	O Yes O No
Do you have to push or strain to start urinating?	O Yes O No
Have you ever noticed visible blood in your urine?	O Yes O No
Do you have any problems achieving or maintaining an erection?	O Yes O No
Do you have a history of kidney stones?	O Yes O No
Do you have a history of recurring urinary tract infections?	O Yes O No
Did you have any urinary problems as a child?	O Yes O No
If yes, please specify? ____________________	
Have you ever had any surgery on or injury to the urinary tract?	O Yes O No
If yes, please specify? ____________________	
Have any of your blood relatives had urinary problems or prostate cancer?	O Yes O No
If yes, please specify? ____________________	

Constitutional symptoms

Fever	O Yes O No
Chills	O Yes O No
Weight loss	O Yes O No

Eyes

Blurred Vision	O Yes O No
Double Vision	O Yes O No
Painful eyes	O Yes O No

Allergies

Hay Fever	O Yes O No
Drug Allergies	O Yes O No
Other: __________	O Yes O No

Neurological

Headaches	O Yes O No
Dizzy spells	O Yes O No
Numbness	O Yes O No

Gastrointestinal

Abdominal pain	O Yes O No
Nausea/Vomiting	O Yes O No
Constipation	O Yes O No
Diarrhea	O Yes O No
History of ulcers	O Yes O No
History of hepatitis	O Yes O No
Bloody Stools	O Yes O No

Hematologic/Lymphatic

Blood clotting problem	O Yes O No
Prior blood transfusions	O Yes O No
Swollen glands	O Yes O No

Skin

Rash	O Yes O No
Boils	O Yes O No
Itching	O Yes O No

Musculoskeletal

Joint Pain	O Yes O No
Neck Pain	O Yes O No
Back Pain	O Yes O No

Ears/Nose/Throat

Ear infection	O Yes O No
Sore throat	O Yes O No
Sinus Problems	O Yes O No

Endocrine

Excessive thirst	O Yes O No
Too hot/cold	O Yes O No
Tired/Sluggish	O Yes O No

Respiratory

Wheezing	O Yes O No
Frequent cough	O Yes O No
Shortness of breath	O Yes O No
Other: __________	O Yes O No

Cardiovascular

Chest pain	O Yes O No
Varicose veins	O Yes O No
High blood pressure	O Yes O No
History of heart attack	O Yes O No
History of heart failure	O Yes O No

Signature: ______________________________

Family History:

First name: ______________________ Last name: ______________________________________

Today's date: _____/_____/_____ Date of birth: _____/_____/_____

I was Adopted_________

Mother: Diabetes____ Diabetes Mellitis type 1____ Cancer____ type____________________
Cancer of Kidney____ Enuresis____ Heart Disease____ Hypertension____
Kidney Stones____ Mental Illness____ Stroke____ Unknown____

Father: Diabetes____ Diabetes Mellitis type 1____ Cancer____ type____________________
Cancer of Kidney____ Prostate Cancer____ Enuresis____ Heart Disease____ Hypertension____
Kidney Stones____ Mental Illness____ Stroke____ Unknown____

Siblings: Diabetes____ Diabetes Mellitis type 1____ Cancer____ type____________________
Cancer of Kidney____ Prostate Cancer____ Enuresis____ Heart Disease____ Hypertension____
Kidney Stones____ Mental Illness____ Stroke____ Unknown____

Grandparents: Diabetes____ Diabetes Mellitis type 1____ Cancer____ type____________________
Cancer of Kidney____ Prostate Cancer____ Enuresis____ Heart Disease____ Hypertension____
Kidney Stones____ Mental Illness____ Stroke____ Unknown____

Please describe any other family illnesses you feel are important to your medical history: ____________
____

Social History:

Alcohol Use: Have you had any alcohol to drink in the last year? Yes____ No____
How often do you drink? 1 or less per month______ 2-4 per month______ 2-3 per week______
4 or more per week_____

Recreational Drug Use: Never____ Past____ Current____ Type________________________

Tobacco Use: Never____ Former Smoker____ When did you quit______ Every day Smoker_____
5 or less per day_____ 1 pack or less per day_____ 1-2 packs per day_____ Chew Tobacco_____
Other type of tobacco____________________
Are you interested in quitting? Yes____ No____

Signature: ____ Date: __________________

Carson Urologists, Ltd.

1425 Vista Lane
Carson City, NV 89703
(775) 883-1030

I Authorize Carson Urologists, Ltd. to discuss my health information with the following person(s): ***DOES NOT APPLY TO OTHER PHYSICIANS***

Name	Relationship
______________________	______________
______________________	______________
______________________	______________
______________________	______________
______________________	______________

Patient signature ______________________ Date ______________________

CARSON UROLOGISTS, LTD.

1425 Vista Lane Carson City, NV 89703
James A. Cunningham, M.D., Roland N. Chen, M.D. Randall G. Nixon, M.D.,
Michael P. Sheehan, RNFA, NPc, CUNP, Julie R. Rowan, APRN

Thank you for choosing Carson Urologists for your medical care. We are committed to providing care which is efficient, courteous and competent. Due to new **HIPAA** laws regarding your Protected Personal Health Information (PHI) our New Patient packets are lengthy and for this we apologize. The new HIPAA laws are for your protection. We use your PHI only for treatment, payments and healthcare operations. Any other use of your PHI will require additional authorization from you. *Please ask for a copy of our Notice of Privacy Policies at the reception desk for all information regarding your Protected Health Information.*

OUR FINANCIAL POLICY: (Please take time to read)

Please understand that payment, accurate billing and collection of your bill are considered a part of your treatment. Necessary forms need to be completed to expedite carrier payment. Each time you visit our office you will be required to sign off that we have your most current insurance information or that you do not have insurance. If we bill the incorrect insurance because you did not inform our office of an insurance change, you will receive the bill.

Any charges incurred through the emergency room, consultation in the hospital, and charges incurred in our office are your responsibility. We will be happy to file your insurance for you (workers comp excluded). .

Part of our service to you is to complete FMLA/disability paperwork. There is a fee of $10 per form which is due upon the receipt of the paperwork.

We accept checks, cash, Visa, MasterCard, Discover card or Care Credit. If your check comes back to us for non-sufficient funds, we will charge a $35 fee to cover the bank charges and we will ask for all subsequent payments to be made by cash or credit card.

You will be required to pay your portion in full at the time of service. If we have filed with your insurance and you have a remaining balance due, you are required to pay the balance in full within 30 days of your statement. If not paid, your account will be referred to our collection agency. ***When your account is referred to an outside collection agency your balance will be increased by 50% for collection processing. This can and will impact your financial credibility. This is a substantial amount added to your current balance.***

Disclosure:
I understand that if my insurance carrier denies any charges or I have no insurance to file for services I am responsible for the bill. I have read the financial policy and understand my responsibility.
I am responsible for any deductibles, co-payments or co-insurance at the time of service. Non-payment of my expected co-pay at the time of service will result in an additional $15.00 fee to my account. This fee covers the administrative cost of a statement the office normally would not have to process.

If you have any questions concerning this notice, please feel free to ask any representative of our office.

Signature: ________________________________ Date: ____________________

Print name: ________________________________

Narcotic Prescribing Policy

Agreement for prescription request and use of controlled substances:

Part of your treatment program may involve the prescription of analgesic medications (pain medications). These medications have both beneficial effects as well as possible side effects. Analgesic medications often produce substantial relief of even the most severe pain and can improve a patient's quality of life (QOL). Side effects are usually mild and manageable but may include sedation, fatigue, euphoria, stimulation, confusion, and/or somnolence. Other side effects involve the stomach and intestines and include nausea or vomiting, constipation, dry mouth, and changes in appetite.

Although the majority of patients control their medications well and follow their provider's orders strictly, there are some patients that are prone to medication dependency or addiction. Because of this, the state and federal regulatory bodies have placed strict guidelines for controlled substances. This means that the use of these medications involves special responsibilities on the part of the ***patient*** and the ***healthcare provider***. This is especially true when opioid medications (narcotic medications such as codeine, hydrocodone, oxycodone, propoxyphene, methadone, and morphine among others) are prescribed.

It is important that you read and understand the following policies and procedures as well as the rights and responsibilities of both the patient and providers.

1. Adhere to your provider's orders on how to take your pain medication. **Never take more than the prescribed dose without first consulting your provider**. Do not abruptly stop your pain medications since withdrawal symptoms may occur and some of these symptoms are dangerous.
2. Do not take your narcotic medications in any altered form or other than prescribed or intended. It can be life threatening to chew or crush long acting medications such as Avinza, Oxycontin, MS Contin, and Kadian.
3. When asking another provider to refill medications, you are required to inform them of the medications that you are receiving from this office.
4. If your provider agrees to prescribe medications for you, then no other provider should prescribe any medication with pain relieving or sedative properties without the provider's knowledge and permission.
5. No emergency room visits expressly for the purpose of receiving opioid medications (including Demerol), especially by injection, will be permitted.
6. It is imperative that all requests for pain medication be submitted at least 7 days before you might run out of your medication. Certain narcotics require a hand written prescription and these will only be written when providers are not with patients. Covering or on call providers will not refill prescriptions.
7. Every time a prescription is written, we will document the medication, quantity, and expected refill date.
8. Many insurance policies restrict the type and quantity of medication prescribed. It is your responsibility to work with your insurance company for any variance beyond their policy coverage.
9. It is important to understand the side effects of all pain relieving medications such as drowsiness, poor coordination, and impaired reflexes. Therefore, it is your responsibility to exercise caution when attempting to operate a motor vehicle.

10. You must keep follow up appointments as outlined and recommended. Our practice is busy caring for patients with serious problems and the schedule is always full. It is essential to plan in advance in order to make sure that all patients are seen in a timely manner and have full opportunity to address their individual needs.
11. If you run out of medication, either because of poor planning or because of taking the medication in excess of what was prescribed, you are responsible for the consequences, including poor pain control or any withdrawal symptoms.
12. **It is a felony in the state of Nevada to obtain controlled substances from multiple providers (NRS 453.3912). We will periodically run pharmacy checks and will discontinue writing prescriptions for pain medications if you are found in violation of the law.**
13. Lost, stolen, or misplaced prescriptions or medications will not be replaced. Selling medication or sharing medication with family, friends, or any other person is illegal and will not be tolerated.
14. If we have recommended a procedure that would eliminate your pain and you choose not to proceed, your pain and the consequences associated with it are your responsibilities. **We will not continue to write prescriptions for narcotics when there is a procedure that would eliminate your pain.**
15. If you are or may become pregnant, you must inform your provider immediately. Narcotic medications can seriously and adversely affect unborn or breast feeding children.

We expect you to take the above patient responsibilities seriously. We will attempt to care for you in the best possible manner and take that responsibility seriously as well. Failure to comply with our policies may result in immediate dismissal from our practice or termination of all or part of your medical regimen, regardless of any withdrawal effects or other consequences.

Bring all mediations prescribed by this clinic in the original bottles to your appointments. If new medication is to be prescribed, the remaining tablets will need to be given to the healthcare provider.

I have read and understand all of the above policies and all of my questions have been answered. I agree to comply with all of the conditions for prescriptions of pain medication set forth by my provider(s). I understand that failure to comply may result in the termination of the prescribing of my pain medication and/or my immediate dismissal from my provider's care.

Patient Name:

Patient Signature:

Date

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel or reschedule your appointment. It is therefore requested that if you must cancel or reschedule your appointment, you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. Failure to give 24 hours notice or not showing up for your appointment may be subject to the following fees:

- First & second incident: $50 office visit or $150 procedure fee billed to your account.
- Third incident: subject to above fees billed to your account and you may be discharged from the practice, thus being denied any future appointments.

These fees are the sole responsibility of the patient/representative and must be paid in full before the patient's next appointment.

We have instituted reminder processes to help you remember to keep your appointment, but if you fail to show and fail to give notice, we have no choice but to add this charge to your account.

Please sign that you have read understand and agree to this Cancellation and No Show Policy.

______________________________ **Date of Birth**__________________

Patient Name (Please Print)

______________________________ **Date**__________________

Signature of Patient or Patient Representative

Carson Urologists, Ltd.

James A. Cunningham, M.D. * Roland N. Chen, M.D. * Randall G. Nixon, M.D.
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1425 Vista Lane
Carson City, NV 89703
Phone: (775) 883-1030 Fax: (775) 884-6231

~ Medical Records Release Authorization ~

Please send all medical records including lab, pathology, and x-ray results to:

____
(Physician or Facility Name)

____
(Address)

____
(City/State/Zip)

______________ ______________
(Phone) (Fax)

Patient Name: ______________________

Date of Birth: ______________________

Parent or Guardian: ______________________

______________________ ____________
(signature) (Date)

If you request records to be emailed, please understand that emails are not completely secure. There are risks associated with email; risks include access by someone other than the patient.