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 [ ] Divorce [ ] 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: _____

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
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Patient signature

Date

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

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: _____

(PLEASE SEE OTHER SIDE)

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____ Healthy____

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

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

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

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: _____

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 History – please list

All current and past medical problems:

All past surgeries:

All current medications/vitamins:

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

Signature: _____ **(PLEASE SEE OTHER SIDE)**

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

CARSON UROLOGISTS, LTD

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 $12 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: _____ DOB: _____

CARSON UROLOGISTS, LTD

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