Associated Urologists of North Carolina

Patient Registration Form

Date of Registration _____

Last Name _____ First Name _____

Middle Name _____ Suffix _____

Sex: M F Previous Last Name _____

Date of Birth (M/D/Y) _____ Social Security # _____

Home Address _____

Home Address Cont. _____

Zip _____ City _____ State _____

Country _____

Phone # _____ Work# _____

Cell # _____

No Email: Email _____

Contact Preference Language:

Race: Caucasion African American Other

Ethnicity: Hispanic Non-Hispanic

Marital Status Single Married Divorced Separated

Homebound: No Yes

How did you hear about us? _____

Guardian Last Name _____ Guardian First Name _____

Guardian Middle Name _____ Suffix _____

Emergency Contact Name _____

Emergency Contact Relation _____

Emergency Contact Phone _____ Mobile Phone _____

Next of Kin Name _____ Next of Kin Relation _____

Next of Kin Phone _____

I give permission to share medical information with: No One Guardian

Next of Kin Emergency Contact Guarantor

Other _____

I give permission to share financial information with: No One Guardian

Next of Kin Emergency Contact Guarantor

Other _____

Permission to leave message on answering machine / voice mail: Yes No

Guarantor Information (name to whom statements are sent) Same

Patient's Relationship to Guarantor _____

Guarantor Last Name _____

Guarantor First Name _____

Guarantor Middle Name _____ Suffix _____

Guarantor Date of Birth (M/D/Y) _____

Guarantor mailing address same as patient's address? Yes No

Guarantor Address _____

Guarantor Zip _____ City _____ State _____

Country _____

Patient Mailing Address **Same**

Mailing Address _____

Mailing Zip _____ City _____ State _____

Alternate Phones None Home # _____

Work # _____ Cell # _____

Spouse Name _____

Spouse Date of Birth _____ Social Security # _____

Parents

Mother's information Default patient info

Name _____

Address _____

Zip _____ City _____ State _____

Country _____

Father's information Default patient info

Name _____

Address _____

Zip _____ City _____ State _____

Country _____

Employment (e.g., full-time, part-time, self-employed, retired, etc.)

Employer _____ Occupation _____

Address _____

Zip _____ City _____ State _____

Employer Phone _____

Insurance

I do not have insurance and will be responsible for payment

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Primary Insurance _____

Insurance company _____

Type

Address _____

Zip _____ City _____ State _____

Phone _____ Fax _____

Policy Information

Policy # _____ Effective date _____

Group # _____ Expiration date _____

Policy holder information Same as patient information

Last Name _____

First Name _____ Middle Name _____

Address _____

Zip _____ City _____ State _____

Relationship to patient: Self Spouse Other _____

Date of Birth _____ Social Security # _____

Policyholder Phone _____

Employer _____ Employer Phone _____

Employer Address _____

Zip _____ City _____ State _____

Secondary Insurance None

Insurance company _____

Type _____

Address _____

Zip _____ City _____ State _____

Phone _____ Fax _____

Policy Information

Policy # _____ Effective date _____

Group # _____ Expiration date _____

Policy holder information Same as patient information Same as primary

ins. holder Last Name _____

First Name _____ Middle Name _____

Address _____

Zip _____ City _____ State _____

Relationship to patient: Self Spouse Other _____

Date of Birth _____ Social Security # _____

Policyholder Phone _____

Employer _____ Employer Phone _____

Employer Address _____

Zip _____ City _____ State _____

Primary Healthcare Provider

Name

Address

Zip _____ City _____ State _____

Office Phone _____ Office Fax _____

Referring Healthcare Provider Same as Primary Healthcare Provider

Name _____

Address _____

Zip _____ City _____ State _____

Office Phone _____ Office Fax _____

Treating Healthcare Specialist e.g., cardiologist, gastroenterologist, oncologist

Name

Address

Zip _____ City _____ State _____

Office Phone _____ Office Fax _____

Primary Pharmacy

Name _____

Address _____

Zip _____ City _____ State _____

Phone _____ Fax _____

Secondary Pharmacy

Name _____

Address _____

Zip _____ City _____ State _____

Phone _____ Fax _____

Other Pharmacy

Name _____

Address _____

Zip _____ City _____ State _____

Phone _____ Fax _____

Chief Complaint: What is the main reason for your visit today?

History of Present Illness

Location of the problem: Abdomen Back Groin Bladder

Other

On a scale of 1-10, with 10 being the most severe,

What number best describes the problem?

When did you first notice the problem?

Does anything make the problem worse? Moving About Standing Up

Urinating Other

Does anything help make the problem better? Change Posture Not Moving

Other

Are there any treatments that your doctor would provide that are prohibited by your religious beliefs? No Yes If Yes, Please explain.

Have the symptoms changed over time? No Yes If Yes, Please explain.

How long does the problem last? Minutes Hours Constant

Other

Is anything occurring at the same time? No Yes If Yes, Please explain.

Is the problem constant? No Yes If not, please describe.

Does the problem interfere with your normal function? No Yes If Yes, Please explain

Past Medical, Social History, Family History

Allergies: No drug allergies Latex

Surgery History: Type / Date None

Have you had a blood transfusion? No Yes Artificial heart valve? No Yes

Artificial joint? No Yes Antibiotic prophylaxis required? No Yes

Cardiac stent? No Yes Date

Medical History: List any past or current illness and start date: None

Family History: Condition, relationship (list any serious conditions in your imme-diate family: e.g., diabetes, heart disease, kidney disease, kidney stones, prostate cancer, etc.): None

Medications/herbs/supplements: name, dosage, instructions — (e.g., Flomax 0.4mg once daily) None

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Medications/herbs/supplements (continued):

Are you on a special diet? No Yes If yes, please explain.

Date of last physical examination

What is your Height? ft. in. **What is your Weight?** lbs.

Smoking History Never Smoked Former Smoker Current Smoker

Current Some Day Smoker Started Smoking

Stopped Smoking Amt: Day Week

Chew Dip tobacco Amt: Day Week

Do you drink alcohol? Yes Not anymore Never

Drinks per Day Week Month Year

Type: Beer Liquor Wine

Present Or Prior Drinking Habits: Social Light

Moderate Excessive

Quit (year) Drank how long? Years

How much caffeine do you consume daily? Cups coffee Cups tea

Sodas # Power drinks Other

Type and amt. chocolate

Review of Symptoms:

Within the past six months, any problems with any of the following? If, yes, please explain. None

Any: Fever, chills, or weight loss? No Yes

Any: Blurry vision, Double Vision, or Cataracts? No Yes

Any: Hearing Loss, Stuffy Nose, or Sore Throat? No Yes

Any: Chest Pain, Swollen Ankles, or Irregular Heart Beats? No Yes

Any: Shortness of Breath, Wheezing, or Chronic Cough? No Yes

Any: Stomach Pain, Nausea/Vomiting, or Bowel Changes? No Yes

Any: Back Pain, Neck Pain, or Sore Muscles? No Yes

Any: Rash, Itching, or History of Skin Cancer? No Yes

Any: Swollen Glands, Bleeding, or Transfusions? No Yes

All Patients:

It is the responsibility of the patient to notify this office of pre-admission and/or second opinion requirements of their insurance company at the time of scheduling hospital admissions or surgery. I hereby authorize the release of any medical infor-mation pertinent to my care to my referring physician/family physician and insurance companies and accept responsibility for payment of all medical/surgical fees. I also authorize payment of insurance benefits to Associated Urologists of North Carolina, PA, except when the amount has been paid in full by me.

Signed

Print name

Date

Medicare Patients:

I request that payment under the Medicare Insurance Program be made directly to Associated Urologists of North Carolina, PA, on any bills for service furnished by their physicians during my lifetime. I understand that I may be held responsible for a portion of these bills after Medicare has paid the provider, or for any charges that Medicare does not cover.

Signed

Print name

Date

Submit Form