Urology Associates of Richmond

Patient Demographics

Date: _____ Primary Care MD: _____ Other Referring MD: _____

Name: Last: _____ First: _____ Middle: _____ Suffix: _____

Address: Street: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

eMail: _____ Social Security #: _____

Date of Birth: _____ Age: ____ Marital Status: (Circle One) Single Married Divorced Widowed Other: _____

Race: (Circle One) W/C AA Native Amer. Hisp. Asian Other: _____ Language: English Other: _____

Occupation: _____ Employer: _____

Employer Address: Street: _____ City: _____ State: ____ Zip: _____

Responsible Party: Relationship: SELF (skip below) Spouse Parent Partner Other: _____

Name: Last: _____ First: _____ Middle: _____ Date of Birth: __/__/__

Soc. Security #: _____ Employer: _____

Emergency Contact: Relationship: Spouse Parent Partner Son Daughter Other: _____

Name: Last: _____ First: _____ Phone: _____ Cell: _____

Primary Insurance: _____ Subscriber ID#: _____ Group#: _____

Holder: _____ Holder's DOB: __/__/__ Relationship: _____

Secondary Insurance: _____ Subscriber ID#: _____ Group#: _____

Holder: _____ Holder's DOB: __/__/__ Relationship: _____

I authorize Urology Associates of Richmond, Inc. to release any medical information necessary to process my insurance claims. I authorize payment of benefits to Urology Associates of Richmond, Inc. I authorize Urology Associates of Richmond, Inc. to access any of my medical records for review of x-rays, tests, and / or medical reports needed for my care. I certify that the information given is correct and understand that I am responsible for any charges. Should this account be turned over to a collection agency or attorney, I understand that I am obligated to pay all court costs and reasonable attorney fees. I agree that any overpayments collected on this account may be applied directly to any delinquency for which I am legally responsible.

Signature: _____ Date: _____

Patient Acc#________

Urology Associates of Richmond
HIPAA Access Form for Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose your Protected Health Information (PHI). As provided in our policy, the terms of our notice my change. If we change our notice, you may obtain a revised copy in our office or on our website.

I, ______________________________(Please Print) have read and/or received a copy of Urology Associates of Richmond's Notice of Privacy Practices. **Our privacy policy is available and posted in our office and on our website in the "forms" section where it may be read, printed, and/or downloaded.** I understand that I may ask questions to Urology Associates of Richmond if I do not understand any information contained in the Notice of Privacy Practices.

Patient Signature: ______________________ ***Date***: ___________

UAR MAY CONTACT ME / LEAVE CONFIDENTIAL INFORMATION ON THE FOLLOWING NUMBERS:

Home: ________________________ Yes______ No______

Cell: ________________________ Yes______ No______

Work: ________________________ Yes______ No______

DISCLOSURES TO FAMILY AND FRIENDS

I, ______________________________, give consent for my personal, confidential, and/or financial health care information to be given to the following person(s):

NAME	RELATIONSHIP	CONTACT NUMBER	TYPE OF INFORMATION
			☐ ALL ☐ APPTMTS ☐ PRESCRIPTNS ☐ BILLING ☐ LAB RESULTS
			☐ ALL ☐ APPTMTS ☐ PRESCRIPTNS ☐ BILLING ☐ LAB RESULTS
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			☐ ALL ☐ APPTMTS ☐ PRESCRIPTNS ☐ BILLING ☐ LAB RESULTS

Patient Signature: ______________________ ***Date***: ___________

Our Financial Policy

Thank you for choosing Urology Associates of Richmond as your healthcare provider. The following is a statement of our Financial Policy which we require you to read and sign prior to being seen.

WE ACCEPT CASH, CHECK OR CREDIT CARDS (MasterCard, Visa or Discover Card)

Regarding Insurance:
You will be asked to provide your insurance card(s) at ***EVERY*** visit. This is to ensure that the information we have is correct and that we participate with your plan. All office co-pays are to be paid at the time of service. **This is an insurance company policy.** If you do not have your co-payment, you may be asked to reschedule your appointment. We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for medical care is a contract between you and the carrier.

Insurance vary in coverage, and it is the patient's responsibility to understand his/her medical benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. Patients are responsible for any co-insurance, deductibles, or any non-covered service, which are due at the time of service.

It is the responsibility of the patient to ensure we have a referral on file for your visit, if you have an insurance plan that requires one. If a referral was not obtained, you will be asked to sign a waiver or reschedule your appointment.

Returned Checks:
There is a $29.00 return check fee on all returned checks and any future payments to the office will have to be made by cash, money order, or credit card.

Missed Appointments:
There is a $30.00 fee for missed appointments or appointments that are cancelled without giving us a 24 hour notice.

Collection Fees:
In the event we are placed in the unfortunate position that we must turn your delinquent account over to a Collection Agency and/or Collection Attorney, you will be responsible for all collection cost, including a recovery fee of 30% of the balance due, as well as any and all court cost and attorney fees that may be incurred.

Fees for Forms:
Your Physician and Staff will be happy to fill out any necessary forms that you may need. Routine "Work Notes/Medical Excuses" will be processed without a fee. However, please be advised that due to the time and processes required to fulfill more extensive requests, we reserve the right to charge a fee of $25.00 for this service. These costs are considered non-covered by insurance companies, thus, payment of this fee is due at the time of request.

X_____ Date: _____

Signature of Patient or Responsible Party

Urology Associates of Richmond
Patient Medical Information

Medication:	Dose:	Pills/Day:	Medication:	Dose:	Pills/Day:

Allergy:	Reaction (i.e. rash, etc.)	Allergy:	Reaction (i.e. rash, etc.)

Pharmacy: _____ **Pharmacy Phone:** _____

Mail Order Pharmacy: _____

Weight: _____ **Height:** _____

Social History:

Marital Status: (circle) **Single Married Separated Divorced Widowed Partner**

Occupation: _____

Alcohol Consumption: **None Social** _____ **Drinks/ day** _____ **Beers / day**

Tobacco Use: (circle) **Never**
Current: _____ **packs /day** _____ **cigs/day** _____ **Smokeless**
Former: _____ **packs/day** **Quit:** (# of years or date) _____

Family History: (please indicate only Father / Mother / Brother / Sister / Child)

Disease	Family Member	Disease	Family Member
Hypertension		BPH / Large Prostate	
Diabetes		Prostate Cancer	
Heart Disease		Kidney Stones	
Lung Disease		Kidney Disease/Dialysis	
Colon Cancer		Kidney Cancer	
Breast Cancer		Other:	

Past Medical History: (Have you ever been diagnosed with…) please circle

Heart:
Angina / Chest Pain
Arrhythmia
Atrial Fibrilation
Congestive Heart Failure
Coronary Artery Disease
Heart Attack
Heart Murmur
Heart Valve Disease

Vascular:
Aortic Aneurysm
Peripheral Vascular Disease

Blood:
Anemia
Bleeding Disorder
Deep Vein Thrombosis
Hemophilia
Leukemia
Sickle Cell Disease
Religious Objection to transfusion

Endocrine:
Diabetes
Thyroid Disease
Gout
Low Testosterone
Infertility

General:
Environmental Allergies
Hypertension
High Cholesterol
Obesity
HIV/AIDS
Sleep Apnea
Osteoporosis

Gastrointestinal:
Gall Stones
Diverticulitis
Diverticulosis
GERD / Reflux
Hemorrhoids
Ulcer
Irritable Bowel Syndrome
Hepatitis
Pancreatitis
Liver Disease
Crohn's Disease
Ulcerative Colitis
Colon Polyps

Urology
BPH/ Large Prostate
Incontinence
Inability to Void
Bladder Infection
Prostate Infection
Testicular Infection
Interstitial Cystitis
Kidney Infection
Kidney Stones
Bladder Stones
Kidney Cysts
Polycystic Kidney Disease
Kidney Failure
Dialysis
Kidney Transplant
Congenital Kidney Disease
Undescended Testicle
Warts
Sex Transmitted Disease

GYN:
Ovarian Cysts
Uterine Fibroids
Endometriosis

Head & Neck:
Cataracts
Glaucoma
Hard of Hearing
Visual Impairment
Sinusitis

Musculoskeletal:
Arthritis
Back Pain
Fibromyalgia

Neurological:
Stroke
Spinal Cord Injury
Seizure Disorder
Alzheimer's Disease
Parkinson's Disease
Multiple Sclerosis
Migraine
Herniated Disk

Psychiatric:
Anxiety
Depression
Mental Illness

Respiratory:
Asthma
Bronchitis
COPD / Emphysema
Pneumonia
PE – Pulm. Embolism

Tumors:
Kidney Cancer
Prostate Cancer
Bladder Cancer
Testicular Cancer
Breast Cancer
Cervical Cancer
Cancer of Uterus
Ovarian Cancer
Lung Cancer
Lymphoma
Leukemia
Melanoma
Pancreatic Cancer
Colon Cancer
Rectal Cancer
Brain Tumor

Past Surgical History: (Please Circle previous surgical procedures you have had)

Heart:
AICD / Pacemaker
Angioplasty / Stents
Heart Bypass
Heart Valve

Vascular:
Carotid Artery Surgery
Vascular Surgery / Leg Bypass

General:
Hernia
Splenectomy (Spleen)

GI:
Appendix
Gall Bladder
Bowel Resection
Gastric Bypass or Banding
Rectal Surgery

Urology:
Bladder
Tumor
Cystectomy

Continence
Collagen Injection
Sling/"Tack"
Other

Stones
ESWL/ Lithotrpsy
Ureteroscopy
Don't Know

Kidney
Removal
Partial Removal
Other

Ureter
Stent
Other

Penis
Implant
Removal
Other

Testicle/Scrotum
Removal
Cyst
Hydrocele -Fluid
Varicocele- Veins

Prostate- Voiding
TURP
Laser
Other

Prostate – Cancer
Biopsy
Removal
Seeds
External Radiatn

OB / Gyn:
Breast Surgery
Ovarian Cyst / Removal
Vag. Hysterectomy
Abd. Hysterectomy
Bladder or Rectal Suspension
Laser Ablation Endometriosis
Uterine Ablation (NOVAsure)
D and C
Tubal Ligation

Vaginal Deliveries
_____
Caesarian Sections
_____
Miscarriages/Abort.
_____

Head and Neck:
Cataract Surgery
Other Eye Surgery
Ear Surgery
Facial/Nasal/Sinus Surgery
Thyroid Surgery
Parathyroid Surgery
Brain Surgery

Musculoskeletal:
Amputation
Shoulder Surgery
Back Surgery
Hip Surgery
Knee Surgery
Ankle or Foot Surgery

Respiratory:
Lung Surgery

Skin:
Basal Cell
Melanoma
Squamous Cell

Recent Symptoms: (please circle)

General:
Chills
Fevers
Fatigue
Headache
Hot Flashes
Weight Gain
Weight Loss

Eyes
Cataracts
Glaucoma
Visual Changes

Allergies:
Environmental
Food

Neurologic:
Dizziness
Disorientation
Fainting
Headache
Arm or Leg Weakness

Endocrine:
Excessive thirst

Abdominal:
Nausea / Vomiting
Abdominal Pain
Constipation
Diarrhea

Heart:
Chest Pain
Shortness of Breath
Swelling
Chest Palpitations

Skin:
Rash
Warts

Musculoskeletal:
Arthritis
Back Pain
Joint Pain

Head & Neck:
Nasal / Sinus
Congestion
Hearing Problems
Sore Throat

GYN:
Heavy Vag. Bleeding
Irregular Vag. Bleed
Pelvic Pain/Cramping
Vag. Pressure/Mass
Vaginal Discharge
Painful Intercourse

Respiratory:
Asthma
Cough
Wheezing
Difficulty Breathing

Blood:
Bleeding Problems
Easy Bruising

Psychiatric:
Anxiety
Depression

Name: _____ ACCOUNT#_____

1. If you are over age 65, have you experience any urinary leakage?
   YES_____ NO_____
   *with an urge to void: YES_____ NO _____
   *with a cough or sneeze: YES_____ NO_____

2. If you are over age 65, have you undergone a DXA scan to screen for bone density strength (osteopenia or osteoporosis)
   YES_____ NO_____ if yes, approximate date: _____

3. If you are female between the ages of 40 and 69, have you had a mammogram?
   YES_____ NO_____ if yes, approximate date: _____

4. If you are between the ages of 51 and 75, have you had a colonoscopy?
   YES_____ NO_____ if yes, approximate date: _____

5. If you are 18 or older, did you receive an influenza vaccine during the flu season?
   YES_____ NO_____ if yes, approximate date: _____

6. If you are age 65 or older, have you received the Pneumococcal(Pneumonia) vaccine?
   YES_____ NO _____ if yes, approximate date: _____

7. If you are 18 or older, are you a current tobacco user or do you use smokeless tobacco?
   YES_____ NO _____

Reason for your visit: Routine Apptmt. Recent Surgery Procedure
Other: _____

Today I feel: **Well** **Ill** **Better** **Worse** **Other:** _____

Recent Symptoms (Please Circle):

General:
Chills
Fevers
Fatigue
Hot Flashes

Eyes
Cataracts
Glaucoma
Visual Changes

Neurologic:
Dizziness
Disorientation
Fainting
Headache

Abdominal:
Nausea / Vomiting
Abdominal Pain
Constipation
Diarrhea

Heart:
Chest Pain
Shortness of Breath
Swelling
Chest Palpitations

Skin:
Rash
Warts

Musculoskeletal:
Arthritis
Back Pain
Joint Pain

Respiratory:
Asthma
Cough
Wheezing
Difficulty Breathing

Please Circle the number for each question:

Over the last month I've:	**Never**	**1 in 5 Times**	**Less than ½ the time**	**Half the Time**	**More than ½ the Time**	**Almost Always**
Felt I didn't empty completely	0	1	2	3	4	5
Had to empty again less than 2 hours later	0	1	2	3	4	5
Stream stopped and Started	0	1	2	3	4	5
Unable to Postpone Voiding	0	1	2	3	4	5
Had a Weak Stream	0	1	2	3	4	5
Had to Push or Strain	0	1	2	3	4	5

# of Times Up at Night to Empty _____

How would you feel if you were to remain no better or worse than you currently are?	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Unsatisfied	Terrible
	0	1	2	3	4	5

Incontinence: Do you leak urine? Yes No

If yes: When I cough / laugh Can't make it on time Both Don't know when I will

I use: _____ Pads / Diapers / day _____ Pads / Diapers / Night

In compliance with recent **US Government** regulations, all patients with: **Obesity, High Blood Pressure, Tobacco Use** are encouraged to see their **primary care physician** to manage these issues. People over the age of 50 should discuss getting an **influenza vaccine** with their primary care physician as well. Please note, primary management of these problems is not within the general scope of standard urologic practice. However, failure to address these issues with your primary care physician may have a detrimental impact on your urologic health. Should you have questions regarding the role these disorders may play in your urologic diagnosis, please do not hesitate to discuss this with your urologist.