

PATIENT REGISTRATION

ARKANSAS UROLOGY, P.A.

ACCT.# _____

CLINIC LOCATION _____

Date _____ Appt. Time _____

Pharmacy _____

Today's appt. is with Dr. _____

Pharmacy phone _____

PATIENT INFORMATION

Name _____ Sex _____ Age _____ Date of Birth _____

Mailing Address _____ Social Security _____

Physical Address _____ Patient Place of Employment _____

Home Phone _____ Work Phone _____

Pager # _____ Cell Phone _____ Spouse/Parent Name _____

E-Mail _____ Spouse/Parent Work # _____

Name and phone # next of kin not living with you _____

PERSON RESPONSIBLE FOR BILL

Name _____ Home Phone _____ Work Phone _____

Address _____ Relation to Patient _____

OTHER INFORMATION

Who referred you to this clinic? Doctor _____ Specialty _____ City _____

Family Member Friend Name _____ Yellow Pages Advertisement Referral Service

Have you ever seen any of our doctors **as a patient** before? _____ In Office _____ In Hosp. _____

Allergies _____ Latex Allergy: Yes No

Reason for Visit _____

INSURANCE INFORMATION

Primary Insurance Carrier _____ Phone () _____

Address to mail claims _____

Policy # _____ Group # _____ Program # _____

Policyholder Name _____ Address _____

Policyholder Phone _____ Policyholder Birthdate _____ Sex _____

Policyholder Employer/School _____

Policyholder Relationship to Patient _____ Policyholder SSN _____

Does your primary insurance require Pre-Authorization/Pre-certification? Yes No

Are referrals from primary care physician required? Yes No Primary Physician's Name _____

Secondary Insurance Carrier _____ Phone () _____

Address to mail claims _____

Policy # _____ Group # _____ Program # _____

Policyholder Name _____ Address _____

Policyholder Phone _____ Policyholder Birthdate _____ Sex _____

Policyholder Employer/School _____

Policyholder Relationship to Patient _____ Policyholder SSN _____

Is this policy: A. Medicare Supplemental Policy or B. Employer Sponsored Do you have papers from attorney / Work. Comp? Yes No

MEDICAL RELEASE INFORMATION

I Authorize the release of any medical information necessary to process insurance claims for services and/or supplies provided by Arkansas Urology, P.A.

PAYMENT OF BENEFITS

I Authorize payment of medical benefits to Arkansas Urology for services and/or supplies provided by them.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I Understand and agree that, (regardless status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

X _____

Date _____



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ARKANSAS UROLOGY (Patient History Form - FEMALE)

This is a confidential record. Information contained here will not be released without your authorization. Please fill out in detail to help us understand your medical problems and to help us provide the best treatment possible.

Date Seen / /

FOR INTERNAL USE ONLY:

Male Female

NP?

1V FUV

Status

Sh NoSh RESC

Res Date

/ /

Physician Code

First Name **I.** **Last Name**

Number & Street Address

City **State** **Zip Code**

Birth Date / /

Social Security # - -

Account #

Who sent you to the clinic?

Who is your primary physician ?

City **State**

What is the main problem that brought you here ?

Employer: _____

Work Phone: _____

Home Phone: _____

Cell Phone: _____

Parents' Names (if patient is a child):

When did it start?

What makes it worse?

What makes it better?

This condition is getting: worse better stable intermittent

Are there any other symptoms? (e.g. nausea, bleeding, fever)

Are there other urologic problems you would like evaluated or examined? (e.g. incontinence)

1.

2.

3.

Physician use only (Comments/Notes-location, quality, severity, duration, timing, content, modifying factors, associated signs and symptoms).

#	Level
1-3	1 or 2
4+	3-5

Draft

Social Security #

____ - ____ - _____

REVIEW OF SYSTEMS (FEMALE)

Do you now or have you had any problems related to the following symptoms? Darken the circle (yes) Y when the symptom is present or (no) N when not present.

CONSTITUTIONAL
 Y N
 Fever
 Chills
 Headache
 Other _____

ENDOCRINE
 Y N
 Excessive Thirst
 Too Hot / Cold
 Tired / Sluggish
 Hot Flashes
 Other _____

CARDIOVASCULAR
 Y N
 Chest Pain
 High Blood Pressure
 Varicose Veins
 Other _____

ALLERGIC / IMMUNOLOGIC
 Y N
 Hay Fever
 Drug Allergies
 Other _____

NEUROLOGICAL
 Y N
 Tremors
 Dizzy Spells
 Numbness / Tingling
 Other _____

EYES
 Y N
 Impaired Vision
 Pain
 Other _____

Gynecologic
 Y N
 Abnormal Menstrual Bleeding
 Pelvic Pain
 Discharge
 Other _____

GASTROINTESTINAL
 Y N
 Abdominal Pain
 Nausea / Vomiting
 Diarrhea or Loose Stool
 Blood in Stool
 Other _____

HEMATOLOGIC / LYMPHATIC
 Y N
 Swollen Glands
 Blood Clotting Problems
 Other _____

RESPIRATORY
 Y N
 Wheezing
 Frequent Coughing
 Shortness of Breath
 Other _____

PSYCHOLOGIC
 Y N
 Do you have a depressed mood?
 Are you overly anxious?
 Other _____

INTEGUMENTARY (skin)
 Y N
 Skin Rash
 Boils
 Varicose Veins
 Other _____

EAR / NOSE / THROAT / MOUTH
 Y N
 Ear Infection
 Sore Throat
 Sinus Problems
 Other _____

Physician Use Only: (Comments/Notes)

#	Level
0-1	1 or 2
2-9	3
10+	4 or 5



Draft

Social Security #

____ - ____ - _____

SECTION I - cont.

PAST SURGICAL HISTORY (FEMALE) - PFSH cont.

VAGINAL SURGERY Y N when _____

Cystocele
 Rectocele
 Enterocele

Other _____

KIDNEY STONE SURGERY Y N when _____

Stone Extraction with Scope
 ESWL (Shockwave Lithotripsy - no scar)
 Stent
 Open Surgical Removal (big scar)
 Percutaneous Removal (small scar in flank)

Other _____

KIDNEY SURGERY Y N (removal or repair) when _____

Right
 Left

HERNIA Y N when _____

Right
 Left
 Incisional
 Umbilical

GALLBLADDER SURGERY Y N when _____

Laparoscopic (small scar)
 Open (big scar)

HEART SURGERY Y N when _____

Open Surgery
 Bypass
 Heart Valve
 Angioplasty / Stent

BACK SURGERY Y N when _____

NECK SURGERY Y N when _____

VASCULAR SURGERY Y N when _____
(Blood Vessel)

EYE SURGERY Y N when _____

Other - please list with Date _____

Draft

Social Security #

				-			-				
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**SECTION II
SOCIAL HISTORY - cont.**

Y N

Do you drink beverages with caffeine?

Please enter the # per day:

colas ?

--	--	--

cups of coffee ?

--	--	--

glasses of tea ?

--	--	--

Y N

Do you drink alcohol?

What Type?

--	--	--	--	--	--	--	--	--	--

Amount?

--	--	--	--	--	--	--	--	--	--

Y N

Do you smoke or chew tobacco products?

What Type?

--	--	--	--	--	--	--	--	--	--

Amount?

--	--	--	--	--	--	--	--	--	--

SECTION III

FAMILY HISTORY:

If the answer to any of these questions is yes, please tell which relative:

Do you have a family history of

Y N

cancer of the kidneys, ureters or bladder, or any other part of the urinary tract?

Relative?

--	--	--	--	--	--	--	--	--	--

urinary tract infections?

Relative?

--	--	--	--	--	--	--	--	--	--

kidney stones?

Relative?

--	--	--	--	--	--	--	--	--	--

kidney disease?

Relative?

--	--	--	--	--	--	--	--	--	--

Thank you for your time and cooperation!

Arkansas Urology reviews patient records as a part of our ongoing process to improve patient services as well as assist with research. Do we have your permission to use your information in an anonymous manner? (In other words, we will not use your name.)

Y N

Patient Signature: _____

Physician Signature: _____