

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 _____
Last First M.I.

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 _____
Last First M.I.

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 - MALE)

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 or impotence)

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 #

□□□□ - □□ - □□□□□□

MALE VOIDING SYMPTOMS

TAKING THE QUIZ

Darken the circle that best represents your response to each of the following questions. The question is designed to gauge the severity of any symptoms you may be experiencing.

	Not at all	Less than 1 time in 5	Less than half of the time	About half of the time	More than half of the time	Almost always	Patient score
1) INCOMPLETE EMPTYING Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urinating ?	0 ⓪	1 Ⓚ	2 Ⓛ	3 Ⓜ	4 Ⓨ	5 Ⓟ	□
2) FREQUENCY Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating ?	⓪	Ⓚ	Ⓛ	Ⓜ	Ⓨ	Ⓟ	□
3) INTERMITTENCY Over the past month, how often have you found you stopped and started again several times when you urinated ?	⓪	Ⓚ	Ⓛ	Ⓜ	Ⓨ	Ⓟ	□
4) URGENCY Over the past month, how often have you found it difficult to postpone urination ?	⓪	Ⓚ	Ⓛ	Ⓜ	Ⓨ	Ⓟ	□
5) WEAK STREAM Over the past month, how often have you had a weak urinary stream ?	⓪	Ⓚ	Ⓛ	Ⓜ	Ⓨ	Ⓟ	□
6) STRAINING Over the past month, how often have you had to push or strain to begin urination ?	⓪	Ⓚ	Ⓛ	Ⓜ	Ⓨ	Ⓟ	□
7) NOCTURIA Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning ?	⓪	Ⓚ	Ⓛ	Ⓜ	Ⓨ	Ⓟ	□

YOUR TOTAL SCORE □□

	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
QUALITY OF LIFE TO URINARY SYMPTOMS If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0 ⓪	1 Ⓚ	2 Ⓛ	3 Ⓜ	4 Ⓨ	5 Ⓟ	6 Ⓠ



Social Security #

____ - ____ - _____

REVIEW OF SYSTEMS (MALE)

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 _____

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

ENDOCRINE
 Y N
 Excessive Thirst
 Too Hot / Cold
 Tired / Sluggish
 Diminished Sexual Drive
 Decreased Muscle Size or Strength
 Problems with Erection
 Other _____

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

CARDIOVASCULAR
 Y N
 Chest Pain
 High Blood Pressure
 Swelling in Extremities
 Other _____

RESPIRATORY
 Y N
 Wheezing
 Frequent Coughing
 Shortness of Breath
 Other _____

ALLERGIC / IMMUNOLOGIC
 Y N
 Hay Fever
 Drug Allergies
 Other _____

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

NEUROLOGICAL
 Y N
 Tremors
 Dizzy Spells
 Numbness / Tingling
 Other _____

INTEGUMENTARY
 Y N
 Skin Rash
 Boils
 Varicose Veins
 Other _____

EYES
 Y N
 Impaired Vision
 Pain
 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



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Social Security #

____ - ____ - _____

SECTION I

PAST FAMILY and SOCIAL HISTORY (MALE)

Do you now or have you had the following illnesses? Fill in the circle (Yes or No) and please give the approximate date when requested.

Y N

- High Blood Pressure
- Diabetes
- Heart Attack (MI)

when _____

- Heart Failure
- Irregular Heartbeat
- Hepatitis

What Type? _____ when _____

- HIV
- Stroke

when _____

- Emphysema
- Asthma
- Cancer

What Type? _____ when _____

- Anemia
- Bleeding

What Type? _____

- Seizure
- Kidney Stones
- Gout
- Glaucoma
- Thyroid
- Arthritis
- Ulcer
- Sickle Cell
- Mental Illness
- Gallstones

Other Serious Illness _____

PAST SURGICAL HISTORY: Fill in the appropriate circle and give date.

Y N

PROSTATE SURGERY

-
- Transurethral (through scope, no scar)
- Abdominal (scar lower abdomen)

when _____

VASECTOMY

-

when _____

Physician Use Only: (Comments/Notes)



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Social Security #

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

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
 prostate cancer?

Relative?

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

cancer of the kidneys, ureters, bladder, penis, testicles
 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: _____