

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 _____

Social Security Number
____/____/____

Please fill in dots completely.

● correct

● incorrect

FEMALE VOIDING SYMPTOMS

Please darken the circle yes(Y) or no (N) of the choice which best describes your answer to the following questions.

- Y N
- Do you have discomfort with urination?
- Do you have pain or pressure in the bladder that is relieved by urinating?
- Do you have urinary tract infections?
- If yes, very rarely
- 1-2 times per year
- 3 or more times per year
- Do you have blood in your urine?
- Do you have sudden urges to urinate?
- Do you have leakage with sudden urges to urinate? (urgency incontinence)
- Do you leak urine with coughing, sneezing, lifting, or activity? (stress incontinence)
- Do you have leakage of which you are unaware (i.e. you are wet but are not sure when it occurs)?
- Do you wear pads or change clothes because of urine leakage?
- How many pads per day? _____
- Is your urinary flow intermittent (stop and go)?
- Do you have a bulge from your vagina?
- While you are awake, how often do you urinate on average?
- more frequently than every ½ hour
- every ½ hour to 1 hour
- every 1 to 2 hours
- every 2 to 3 hours
- longer than every 3 hours
- On average, how many times a night do you wake up to void?
- none
- one
- two
- three
- four
- five
- six or more
- Do you snore?
- Does it ever wake you up?

Social Security Number

____/____/____

REVIEW OF SYSTEMS (FEMALE)

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

<p>GENITOURINARY</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Burning with urination</p> <p><input type="radio"/> <input type="radio"/> Blood in urine</p> <p><input type="radio"/> <input type="radio"/> Leakage of urine</p> <p><input type="radio"/> <input type="radio"/> Nighttime voiding: _____ times a night</p> <p><input type="radio"/> <input type="radio"/> Pelvic Pain</p> <p><input type="radio"/> <input type="radio"/> Vaginal discharge</p> <p><input type="radio"/> <input type="radio"/> Painful intercourse</p> <p><input type="radio"/> <input type="radio"/> Flank pain <input type="radio"/> Left <input type="radio"/> Right</p>	<p>INTEGUMENTARY</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Skin Rash</p> <p><input type="radio"/> <input type="radio"/> Boils</p> <p><input type="radio"/> <input type="radio"/> Varicose Veins</p>
<p>CONSTITUTIONAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Fever</p> <p><input type="radio"/> <input type="radio"/> Chills</p> <p><input type="radio"/> <input type="radio"/> Headaches</p> <p><input type="radio"/> <input type="radio"/> Unexplained weight loss</p>	<p>NEUROLOGICAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Tremors</p> <p><input type="radio"/> <input type="radio"/> Dizzy Spells</p> <p><input type="radio"/> <input type="radio"/> Numbness/Tingling</p>
<p>EYES</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Impaired Vision</p> <p><input type="radio"/> <input type="radio"/> Pain in eyes</p>	<p>PSYCHIATRIC</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Do You Have a Depressed Mood?</p> <p><input type="radio"/> <input type="radio"/> Are You Overly Anxious?</p>
<p>EARS, NOSE, MOUTH, THROAT</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Ear Infection</p> <p><input type="radio"/> <input type="radio"/> Sore Throat</p> <p><input type="radio"/> <input type="radio"/> Sinus Problems</p>	<p>ENDOCRINE</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Excessive Thirst</p> <p><input type="radio"/> <input type="radio"/> Too Hot / Cold</p> <p><input type="radio"/> <input type="radio"/> Tired / Sluggish</p>
<p>CARDIOVASCULAR</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Chest Pain</p> <p><input type="radio"/> <input type="radio"/> High Blood Pressure</p> <p><input type="radio"/> <input type="radio"/> Swelling in Extremities</p>	<p>HEMATOLOGIC / LYMPHATIC</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Swollen Glands</p> <p><input type="radio"/> <input type="radio"/> Blood Clotting Problems</p>
<p>RESPIRATORY</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Wheezing</p> <p><input type="radio"/> <input type="radio"/> Frequent Coughing</p> <p><input type="radio"/> <input type="radio"/> Shortness of Breath</p>	<p>ALLERGIC / IMMUNOLOGIC</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Hay Fever</p> <p><input type="radio"/> <input type="radio"/> Drug Allergies</p>
<p>GASTROINTESTINAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Abdominal Pain</p> <p><input type="radio"/> <input type="radio"/> Nausea / Vomiting</p> <p><input type="radio"/> <input type="radio"/> Diarrhea or Loose Stool</p> <p><input type="radio"/> <input type="radio"/> Blood in Stool</p>	<p>Physician Use Only: (Comments / Notes)</p> <hr/> <hr/> <hr/> <hr/>
<p>MUSCULOSKELETAL</p> <p>Y N</p> <p><input type="radio"/> <input type="radio"/> Chronic Neck Pain</p> <p><input type="radio"/> <input type="radio"/> Chronic Back Pain</p> <p><input type="radio"/> <input type="radio"/> Pain that Radiates Down Leg Which Side? <input type="radio"/> Right? <input type="radio"/> Left? <input type="radio"/> Both?</p> <p><input type="radio"/> <input type="radio"/> Arthritis</p>	

PAST MEDICAL HISTORY

Section 1

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. *Please mark yes or no for each choice.*

Y	N									
<input type="radio"/>	<input type="radio"/>	Urinary tract problem	→	1) What type?	_____	When?	_____			
				2) What type?	_____	When?	_____			
<input type="radio"/>	<input type="radio"/>	Bleeding	----->	What type?	_____	When?	_____			
<input type="radio"/>	<input type="radio"/>	Cancer	----->	1) What type?	_____	When?	_____			
				2) What type?	_____	When?	_____			
<input type="radio"/>	<input type="radio"/>	Hepatitis	----->	What type?	_____	When?	_____			
<input type="radio"/>	<input type="radio"/>	Stroke	----->	When?	_____					
<input type="radio"/>	<input type="radio"/>	Heart Attack (MI)	----->	When?	_____					
<input type="radio"/>	<input type="radio"/>	Heart Disease								
<input type="radio"/>	<input type="radio"/>	Heart Failure								
<input type="radio"/>	<input type="radio"/>	Irregular Heartbeat								
<input type="radio"/>	<input type="radio"/>	High Blood Pressure								
<input type="radio"/>	<input type="radio"/>	Diabetes								
<input type="radio"/>	<input type="radio"/>	HIV								
<input type="radio"/>	<input type="radio"/>	Emphysema								
<input type="radio"/>	<input type="radio"/>	Pneumonia	----->	When?	_____					
<input type="radio"/>	<input type="radio"/>	Asthma								
<input type="radio"/>	<input type="radio"/>	Anemia								
<input type="radio"/>	<input type="radio"/>	Seizure								
<input type="radio"/>	<input type="radio"/>	Kidney Stones								
<input type="radio"/>	<input type="radio"/>	Kidney Disease	----->	What type?	_____					
<input type="radio"/>	<input type="radio"/>	Gout								
<input type="radio"/>	<input type="radio"/>	Glaucoma								
<input type="radio"/>	<input type="radio"/>	Thyroid Disease								
<input type="radio"/>	<input type="radio"/>	Arthritis								
<input type="radio"/>	<input type="radio"/>	Ulcer								
<input type="radio"/>	<input type="radio"/>	Blood Disorder	----->	What type?	_____					
<input type="radio"/>	<input type="radio"/>	Sickle Cell								
<input type="radio"/>	<input type="radio"/>	Mental Illness / Condition	----->	What type?	_____					
<input type="radio"/>	<input type="radio"/>	Neurological Condition	----->	What type?	_____					
<input type="radio"/>	<input type="radio"/>	Gallstones								
<input type="radio"/>	<input type="radio"/>	Gastroesophageal reflux ("GERD")								
<input type="radio"/>	<input type="radio"/>	Are you pregnant now?		When was your last period?	_____					
<input type="radio"/>	<input type="radio"/>	Have you been pregnant before?								
				How many vaginal deliveries?	0 1	0 2	0 3	0 4	0 5	0 >6
				How many C-section deliveries?	0 1	0 2	0 3	0 4	0 5	0 >6

Other Serious Illnesses, Injuries or Treatments: _____

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

HYSTERECTOMY

Y	N	
<input type="radio"/>	<input type="radio"/>	When? _____
		If "yes", what type?
<input type="radio"/>	<input type="radio"/>	Abdominal (scar lower abdomen)
<input type="radio"/>	<input type="radio"/>	Vaginal

BLADDER SURGERY

Y	N	
<input type="radio"/>	<input type="radio"/>	When? _____
		If "yes", what type?
<input type="radio"/>	<input type="radio"/>	Burch or MMK (scar lower abdomen)
<input type="radio"/>	<input type="radio"/>	Vaginal Incision
<input type="radio"/>	<input type="radio"/>	Pubovaginal Sling
<input type="radio"/>	<input type="radio"/>	Transobturator Sling
<input type="radio"/>	<input type="radio"/>	Not Sure

VAGINAL SURGERY

Y	N	
<input type="radio"/>	<input type="radio"/>	When? _____
		If "yes", what type?
<input type="radio"/>	<input type="radio"/>	Cystocele "Anterior Repair"
<input type="radio"/>	<input type="radio"/>	Rectocele "Posterior Repair"
<input type="radio"/>	<input type="radio"/>	Enterocele
		Other _____

Social Security Number

____/____/____

MEDICATIONS – Do you take any medications? (Include aspirin and vitamin supplements)

YES NO

If yes, please list:

Medication

Dosage or Amount

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Note: If you need more space, please ask for an additional medication sheet.

Do you take?

Y N

Blood Thinner? (e.g. Aspirin, Coumadin, Plavix)

What Types? _____

ALLERGIES:

Y N

Please list medications to which you are allergic:

	Type of Reaction(s):				
	Nausea	Rash	Swelling	Breathing	Other Problems (Describe)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Note: If you need to list more allergies, please ask for an additional allergy sheet.

Y N

Are you allergic to x-ray dye? What type of reaction? _____

Are you allergic to iodine or seafood? What type of reaction? _____

Are you allergic to latex? What type of reaction? _____

SECTION II

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, bladder, or any other part of the urinary tract?

Relative? _____

Type? _____

Urinary tract infections?

Relative? _____

Kidney stones?

Relative? _____

Kidney disease?

Relative? _____

Type? _____

Hematuria/blood in urine?

Relative? _____

