ASSOCIATED UROLOGISTS
OF NASHVILLE, LLP
Adult Urology

PATIENT REGISTRATION FORM

Please answer all questions to the best of your ability

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____ Social Sec. #:_____ Sex: M F

Spouse Name:_____ Date of Birth:_____ Social Sec. #_____ Sex: M F

Current Address: _____
Street City State Zip

Cell Phone: (___)_____ Home Phone: (___)_____

Email:_____

Is Patient Currently in a Skilled Nursing Facility or Hospice Care? Y N Name:_____ Phone:_____

ADDITIONAL INFORMATION

Referring M.D._____ Phone:_____ Family M.D._____ Phone:_____

Patients Employer:_____ Occupation:_____ Phone:_____

Next of Kin: (Someone who does not live with you, in case of emergencies)

Name:_____ Relationship:_____

Address:_____ Phone:_____

Do you have a living Will? ☐ Yes ☐No

Do we have permission to leave messages concerning your appointments and care on your answering machine? ☐Yes ☐No

Do you Authorize Associated Urologists of Nashville, LLP to electronically submit all of your prescriptions and refills? ☐Yes ☐No

Do you Authorize Associated Urologists of Nashville, LLP to mail your test results to the above listed address? ☐Yes ☐No

Do you authorize Associated Urologists of Nashville, LLP to download your medications from a prescription hub? ☐Yes ☐No

HIPAA

Per HIPAA regulations, I hereby authorize Associated Urologists of Nashville, LLP and its employees to discuss my health, financial and/or insurance information with myself and with:

Name:_____ Relationship:_____

INSURANCE INFORMATION

1. We Need to make a copy of your insurance card(s).
2. Does your insurance require: ☐ Referral Number ☐Precertification ☐Second Opinion
3. Do you have Medicare HMO? ☐Yes ☐No

PRIMARY COVERAGE (Usually the Patients Insurance)	SECONDARY COVERAGE (The spouses insurance is secondary if patient has insurance coverage)
Name of Insurance Company:_____	Name of Insurance Company:_____
Policy Holder Name: _____	Policy Holder Name: _____
Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other_____	Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other_____
Member ID # _____	Member ID # _____

INSURANCE RELEASE/PATIENT RESPONSIBILITY

1. I request that payment of authorized insurance benefits be made on my behalf to the physicians of Associated Urologists of Nashville, LLP for any services they provide to me. I authorize any holder of medical information about me, to release, to the insurance company any information needed to determine these benefits or the benefits payable for related services. _____
   Initial
2. I hereby authorize this office to release any information acquired to establish a health insurance claim. I authorize this office to obtain previous medical records from other physicians and/or medical facilities, including but not limited to information regarding treatment of drug or alcohol abuse, psychological conditions, HIV testing or an AIDS related condition. _____
   Initial
3. I understand that I am personally responsible for all Charges including deductibles, co-pays, non covered services and any amount not covered by my insurance (except in cases of a contractual agreement between my insurance carrier and my physician). I understand the charges I am responsible for are to be paid at the time of service. Should collection proceedings become necessary, I understand that I will be responsible for a reasonable attorney fees, court cost and all collection cost. _____
   Initial
   - Associated Urologists of Nashville, LLP charges $35.00 for a returned check and future services must be paid for wish cash, money order or cashier's check. _____
     Initial
   - Associated Urologists of Nashville, LLP requires a 24 hour cancellation notice to avoid any charges. We reserve the right to charge $35.00 for no-show appointments without a 24 hour cancellation notice. _____
     Initial
   - Associated Urologists of Nashville, LLP charges $30.00 for completion of FMLA, disability and life insurance application forms. _____
     Initial
   - Associated Urologists of Nashville, LLP charges $25.00 for doing prior authorizations for medications if required by your insurance company. _____
     Initial
4. I authorize my health care provider to use an automated telephone system and/or email to use my name, address, and phone number; the name of my scheduled treating physician, and the time and place of my scheduled appointment or other health care related communication. I also authorize my health care provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments and to leave a reminder message on my voice mail system or answering machine. _____
   Initial
5. I understand that a copy of Associated Urologists of Nashville, LLP privacy practices is available upon request.
   _____
   Initial

_____ _____

Patient Name Patient Date of Birth

_____ _____

Patient Signature Date

New Patient
Intake Form

Please Circle Race:
African American Asian
American Indian Black
Alaskan Native Hispanic
Native Hawaiian
Caucasian
Other Pacific Islander
Unknown
Other:_____

Please circle Ethnicity:
Hispanic Non Hispanic
Latino Unknown

Name:_____ Date of Birth: ____/_____/____

Age:_____ Weight:_____ Height:_____ Gender:_____

Primary Dr.:_____Referring Dr.:_____

What is the main reason for your visit?_____

Preferred Language:_____ Occupation:_____

MEDICATION & ALLERGY LIST

ALLERGIES: None Codeine IVP dye Latex Mycins Penicillin Sulfa Drugs
OTHER ALLERGIES: _____
_____
PHARMACY NAME & ADDRESS: _____
_____
PHARMACY PHONE & FAX NUMBERS:_____

DATE	PLEASE LIST CURRENT MEDICATIONS (Include over-the-counter drugs, vitamins, herbals)	DOSAGE	FREQUENCY	NOTES

Check any past medical problems:

- ☐ Acid reflux
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer; Type_____
- ☐ Chronic UTIs
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: # of years:____
- ☐ Diverticulitis
- ☐ Enlarged Prostate
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Neurologic Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinsons
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Valvular Heart Disease

Other: _____

_____

Check any past surgical History :

	Date:	Gender Specific: Female	Date:	Gender Specific: Male	Date:
☐ Appendectomy	_____	☐ Bladder Suspension	_____	☐ Prostate Surgery	_____
☐ Back Surgery	_____	☐ Breast Biopsy	_____	☐ Penile Prosthesis	_____
☐ Heart Bypass	_____	☐ Cesarean Section #___	_____	☐ Prostate Biopsy	_____
☐ Colon Surgery	_____	☐ Hysterectomy	_____	☐ Scrotal Area Surgery	_____
☐ Heart Stent	_____	☐ Mastectomy R / L	_____	☐ Testicle Removal	_____
☐ Cystoscopy	_____	☐ Pubovaginal Sling	_____	☐ Varicocele Surgery	_____
☐ Gallbladder Removal	_____	☐ Tubal Ligation	_____	☐ Vasectomy	_____
☐ Gastric Bypass	_____	☐ Vaginal Delivery # ___	_____	☐ Other:	
☐ Hernia Repair	_____	☐ Total Pregnancies #___	_____	_____	
☐ Hip Replacement R / L	_____	☐ Menopause	_____	_____	
☐ Kidney Removal R / L	_____	☐ Hormone Replacement Therapy	_____	_____	
☐ Kidney Stone Removal	_____			_____	
☐ Knee Replacement R / L	_____	☐ Other:		_____	
☐ Laparoscopy	_____	_____		_____	
☐ Pacemaker	_____	_____		_____	
☐ Tonsillectomy	_____	_____		_____	

Check any family history of Illness

Adopted? N Y	Father	Mother	Brother	Sister	Grandparent	Son	Daughter	Runs in Family
☐ Diabetes								
☐ Enlarged Prostate								
☐ High Blood Pressure								
☐ Kidney Stones								
☐ Kidney Failure								
☐ Prostate Cancer								
☐ Kidney Cancer								
☐ Bladder Cancer								
☐ Stroke								
☐ Urinary Tract Infections								
☐ Cancer, Other								
☐ Other								

Social History

MARITAL STATUS: S M D W Children? N Y # of Sons_____ # of Daughters_____

TOBACCO USE: ☐ Current ☐ Former ☐ Never ☐ Unknown Type:_____ Units per day_____ Years Used ____

DRUG USE: ☐ Current ☐ Former ☐ Never ☐ Unknown Type:_____ Years Used_____

Have you tried to quit? N Y Year quit:_____ Passive Smoke Exposure? N Y

Smoker Status: ☐ Current, Every Day ☐ Current status unknown ☐ Former Smoker ☐ Current, Some day smoker ☐ Never Smoker ☐ Unknown if ever smoked

CAFFEINE: N Y Type: _____ Amount of caffeine per day_____

ALCOHOL: Drinks alcohol: N Y Formerly Type: _____ Frequency:_____ Amount:_____ Last Drink:_____

IMMUNIZATIONS: Tetanus Y N _____ Influenza Y N _____ Pneumonia Y N _____

Date: Date: Date:

Review of Systems: Check if you are currently experiencing any of the following symptoms. Please mark Yes or No for each selection. Additional information may be added in the notes section at the bottom of the page.

Constitutional:

No Yes
- ☐ ☐ Chills
- ☐ ☐ Fever
- ☐ ☐ Weight Loss

Other:

Gastrointestinal:

No Yes
- ☐ ☐ Blood in stool
- ☐ ☐ Abdominal Pain
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Increased abdominal girth
- ☐ ☐ Heartburn
- ☐ ☐ Nausea/Vomiting

Other:

Reproductive-Female:

No Yes
- ☐ ☐ Breast Lumps
- ☐ ☐ Breast pain
- ☐ ☐ Vaginal Discharge

Other:

Skin:

No Yes
- ☐ ☐ Hives
- ☐ ☐ Itching skin
- ☐ ☐ Rash
- ☐ ☐ Skin Lesion

Other:

Eyes/Ears/Nose/Throat:

No Yes
- ☐ ☐ Blurred/Double Vision
- ☐ ☐ Hearing Loss
- ☐ ☐ Headache
- ☐ ☐ Sinus infection
- ☐ ☐ Sore Throat
- ☐ ☐ Cataracts

Other:

Genitourinary:

No Yes
- ☐ ☐ Burning with urination
- ☐ ☐ Blood in Urine
- ☐ ☐ Urinary Frequency
- ☐ ☐ Urinary Incontinence
- ☐ ☐ Inability to urinate

Other:

Metabolic/Endocrine:

No Yes
- ☐ ☐ Fatigue
- ☐ ☐ Male Breast enlargement
- ☐ ☐ Hot flashes
- ☐ ☐ Thyroid Disorder

Other:

Musculoskeletal:

No Yes
- ☐ ☐ Back Pain
- ☐ ☐ Joint Pain
- ☐ ☐ Neck Pain
- ☐ ☐ Muscle Pain

Other :

Respiratory :

No Yes
- ☐ ☐ Chronic Cough
- ☐ ☐ Shortness of Breath
- ☐ ☐ Wheezing
- ☐ ☐ Known TB exposure

Other:

Reproductive- Male:

No Yes
- ☐ ☐ Penile Discharge
- ☐ ☐ Erectile dysfunction

Other :

Neurological:

No Yes
- ☐ ☐ Headache
- ☐ ☐ Memory Loss
- ☐ ☐ Seizures
- ☐ ☐ Stroke
- ☐ ☐ Tremors

Other:

Hematologic/Lymphatic:

No Yes
- ☐ ☐ Easy Bleeding
- ☐ ☐ Swollen Glands
- ☐ ☐ Sickle Cell

Other:

Cardiovascular :

No Yes
- ☐ ☐ Chest pain at rest
- ☐ ☐ Chest pain at exertion
- ☐ ☐ Heart Murmur
- ☐ ☐ Leg Cramps with exercise
- ☐ ☐ Palpitations
- ☐ ☐ Arrhythmia
- ☐ ☐ Sleep apnea

Other:

Psychiatric:

No Yes
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Bipolar
- ☐ ☐ Schizophrenia

Other:

Allergy:

No Yes
- ☐ ☐ Diabetes
- ☐ ☐ Immune Deficiency
- ☐ ☐ HIV/AIDS
- ☐ ☐ Hepatitis C

Other: