ASSOCIATED UROLOGISTS
OF NASHVILLE, LLP
Adult Urology

PATIENT REGISTRATION FORM

Please answer all questions to the best of your ability

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:_____ Neurologist._____ Phone:_____

Nephrologist: _____ Phone:_____ Cardiologist:_____ Phone:_____

Pharmacy Name:_____ Phone:_____

Address:_____

Occupation:_____ Phone:_____

Patients Employer:_____

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

- Please Circle Race: African America Asian American Indian Black Alaskan Native Hispanic Native Hawaiian Caucasian Other Pacific Islander Unknown Other:_____
- Please Circle Ethnicity: Hispanic Non Hispanic Latino Unknown

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 with 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

6. I consent to treatment by the Physicians of Associated Urologists of Nashville, LLP/ These Policies supersede and replace any prior policies, verbal or published. _____
   Initial

_____ _____

Patient Name Patient Date of Birth

_____ _____

Patient Signature Date

Medical History

Name:_____Date of Birth: ____/_____/____ Age:_____ Weight:_____ Height:_____

What is the main reason for your visit?_____

PLEASE LIST ALL ALLERGIES AND REACTIONS	
ALLERGEN:	REACTION:

PLEASE LIST CURRENT MEDICATIONS, DOSAGE & FREQUENCY		
	DOSAGE	FREQUENCY
ASPIRIN/NSAIDs/ANTIPLATELETS/ANTICOAGULANTS/BLOOD THINNERS:		
ALL OTHER MEDICATIONS/SUPPLEMENTS/VITAMINS:		

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

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:

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	_____	☐ Other:		_____	
☐ Knee Replacement R / L	_____	_____		_____	
☐ 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								