

## NEW PATIENT DEMOGRAPHIC INFORMATION

| PATIENT INFORMATION   |   |                  |   |                  |               |
|---|---|------------------|---|------------------|---------------|
| Last Name   |   | First Name       |   | Middle Initial   |               |
| Address   |   | Apt #            |   | City/State/Zip   |               |
| Home Tel #  |   | Work Tel #       |   | Ext./Dept.       |               |
| Date Of Birth   |   | Sex              | <input type="radio"/> Male <input type="radio"/> Female | Marital Status   |               |
| Social Security #   |   | Email Address:   |   |                  |               |
| Patient Employer  |   |                  |   |                  |               |
| Employer Address  |   |                  |   |                  |               |
| Spouse's Name   |   | Date of Birth    |   | Spouse's SSN     |               |
| Spouse's Employer   |   |                  | Spouse's Work Phone                                     |                  |               |
| Employer Address  |   |                  |   |                  |               |
| <b>Who is your Primary Care Doctor?</b>                             |   |                  |   |                  |               |
| Who referred you to our office?                                     |   |                  |   |                  |               |
| If referred by a doctor, Dr. Address:                               |   |                  |   | Phone #          |               |
| Person to contact in case of emergency (not living with you)        |   |                  |   | Phone #          |               |
|   |   |                  |   |                  |               |
| Responsible Party Last Name   |   | First Name       |   | Relation         |               |
| Address/City/State/Zip  |   |                  |   |                  |               |
| Telephone   |   | Resp. Party SSN: |   |                  |               |
| <b>INSURANCE INFORMATION</b>  |   |                  |   |                  |               |
| <i>(Please provide copies of your cards and/or insurance forms)</i> |   |                  |   |                  |               |
| <b>1</b>  | <b>First Insurance Name</b>   |                  |   |                  |               |
|   | Policy Holder Last Name   |                  | First Name  |                  | Relationship  |
|   | Certificate/ID #  |                  | Group Name/No.  |                  | Date of Birth |
|   | Is this insurance from an employer group? Y/N   |                  |   | If yes, Employer |               |
| <b>2</b>  | <b>Second Insurance Name</b>  |                  |   |                  |               |
|   | Policy Holder Last Name   |                  | First Name  |                  | Relationship  |
|   | Certificate/ID #  |                  | Group Name/No.  |                  | Date of Birth |
|   | Is this insurance from an employer group? Y/N   |                  |   | If yes, Employer |               |
| <b>ASSIGNMENT OF INSURANCE BENEFITS</b>                             |   |                  |   |                  |               |
| SIGNATURE   | I hereby authorize the attending physician to furnish my insurance carrier with all information which said insurance carrier may request concerning my illness or injury. |                  |   |                  |               |
|   | I additionally assign to the attending physician all payments to which I am entitled for medical and/or surgical expenses relative to the services reported.              |                  |   |                  |               |
|   | This authorization is in effect until rescinded by me in writing. A photocopy of this authorization is as valid as the original.  |                  |   |                  |               |
|   | SIGNATURE (Patient or Parent/Legal Guardian if Patient is a Minor)  |                  |   |                  | DATE          |
| <b>OFFICE USE</b>   |   |                  |   |                  |               |
| Acct. #   | Reviewed By   | Cards Obtained   | Coverage Verified                                       | Comments         |               |
|   |   |                  |   |                  |               |

**PATIENT AUTHORIZATION AND AGREEMENT FORM**

Patient: \_\_\_\_\_ SSN: \_\_\_\_\_

**DISCLOSURE:** Urology Specialists of Nevada is a for-profit professional corporation solely owned and providing medical services to the community.

I hereby authorize Urology Specialists of Nevada to furnish my insurance carrier with all information which said insurance carrier may request concerning my illness or injury and/or illness or injury of my dependent listed above.

I hereby assign to Urology Specialists of Nevada all payment to which I am entitled for medical and/or surgical expenses relative to the services reported, and I understand that I am financially responsible for charges not covered by my insurance company at the time of service.

I understand that Urology Specialists of Nevada bill the insurance as a courtesy to me. I agree to provide accurate and complete information in a timely manner.

I agree to respond to any additional information that the insurance company may request in a timely manner. And, I understand that if the payment of the claim is delayed more than 90 days from the date of service due to my lack of cooperation with the insurance company, the physician(s) reserve the right to collect the balance in full from me immediately.

I understand that all co-payments, co-insurances, deductibles and charges for items not covered by my insurance are payable at the time service is rendered. USON accepts cash, personal checks, Visa and MasterCard only.

I understand that certain lab tests will be sent to an outside laboratory that is not affiliated with this practice and I will be billed by the laboratory for those charges.

I understand that there is an additional charge of \$25.00 for any check that is returned by my bank for any reason. Unpaid returned checks will be sent to the District Attorney's office.

I understand that balances not paid within 90 days from the date of service will be referred to an outside collection agency, and I will be responsible for attorney's fees, collection expenses and interest. I also understand that this account will be listed with local and national credit bureaus.

**BROKEN APPOINTMENT POLICY**

NEW PATIENT \$100.00 ESTABLISHED PATIENT \$30.00

**THESE FEES WILL BE CHARGED FOR BROKEN APPOINTMENTS UNLESS 48 HOURS NOTICE IS GIVEN.**

A photocopy of this authorization is as valid as the original.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_

Age: \_\_\_\_\_ Pharmacy Name/Location: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Medical problems (past & present) & date (approx.) when first occurred:**

| <u>Condition:</u> | <u>Date:</u> | <u>Condition:</u> | <u>Date:</u> |
|-------------------|--------------|-------------------|--------------|
| 1. _____          | _____        | 5. _____          | _____        |
| 2. _____          | _____        | 6. _____          | _____        |
| 3. _____          | _____        | 7. _____          | _____        |
| 4. _____          | _____        | 8. _____          | _____        |

**Surgical procedures (include minor surgeries) & date (approx.):**

| <u>Surgery:</u> | <u>Date:</u> | <u>Surgery:</u> | <u>Date:</u> |
|-----------------|--------------|-----------------|--------------|
| 1. _____        | _____        | 4. _____        | _____        |
| 2. _____        | _____        | 5. _____        | _____        |
| 3. _____        | _____        | 6. _____        | _____        |

**Current medications, dose, date started (approx.):** *{Please attach separate sheet if more than 8}*

| <u>Medication:</u>    | <u>Dose:</u> | <u>Instructions:</u> | <u>Medication:</u> | <u>Dose:</u> | <u>Instructions:</u> |
|-----------------------|--------------|----------------------|--------------------|--------------|----------------------|
| <i>Example: Zocor</i> | <i>20mg</i>  | <i>one per day</i>   |                    |              |                      |
| 1. _____              | _____        | _____                | 4. _____           | _____        | _____                |
| 2. _____              | _____        | _____                | 5. _____           | _____        | _____                |
| 3. _____              | _____        | _____                | 6. _____           | _____        | _____                |

**Allergies to medications, food or substance and if severe, moderate or mild reaction:**

| <u>Allergy:</u>            | <u>Reaction Type:</u>            | <u>Allergy:</u> | <u>Reaction Type:</u> |
|----------------------------|----------------------------------|-----------------|-----------------------|
| <i>Example: Penicillin</i> | <i>Rash, Shortness of Breath</i> |                 |                       |
| 1. _____                   | _____                            | 3. _____        | _____                 |
| 2. _____                   | _____                            | 4. _____        | _____                 |

| <b>OB History (if Female)</b> | <b># of Pregnancies</b> | <b># of Live Births</b> | <b># of C-Sections</b> |
|-------------------------------|-------------------------|-------------------------|------------------------|
| _____                         | _____                   | _____                   | _____                  |

**Current marital status (circle one)?**      Single      Married      Divorced      Widowed

**If married, number of years?** \_\_\_\_\_      **Number of children?** \_\_\_\_\_

Second marriage? \_\_\_\_\_      Number of years? \_\_\_\_\_      Number of children? \_\_\_\_\_

**Highest level of education completed (circle one)?**

Junior high school      High school      Trade school      College 2-yr degree  
College 4-yr degree      Masters degree      PhD      Professional MD/DDS/JD

**Travelled outside of the country recently?**      YES      NO      If yes, where/when? \_\_\_\_\_

**Physical Activity**

Describe your current physical activity level:      None to very little      Moderate      Very Active

Type of activity:    Walking    Jogging    Running    Other \_\_\_\_\_    Frequency: \_\_\_\_\_

**Occupation** \_\_\_\_\_      Retired?      YES      NO      Yr Retired \_\_\_\_\_

**Tobacco Use**    Current smoker?      YES      If yes, how many packs/day? \_\_\_\_\_      NO

Have you ever smoked?    YES    NO    If yes, age when quit \_\_\_\_\_    Age when began \_\_\_\_\_

◆-----◆  
**Caffeine Use**    Type:    SODA      COFFEE      TEA      Approx. # of cups per day? \_\_\_\_\_

◆-----◆  
**Alcohol Use**    Do you drink alcohol?    YES    NO    If yes, type:    BEER      WINE      OTHER

If yes, estimated intake in ounces (*example: 1 beer = 1oz, 1 glass wine = 1 oz, 1 shot vodka = 1 oz*)

Frequency:    DAILY \_\_\_\_\_    WEEKLY \_\_\_\_\_    MONTHLY \_\_\_\_\_    YEARLY \_\_\_\_\_

◆-----◆  
**IV or Recreational Drug Use**      NONE      List your drug(s) of choice: \_\_\_\_\_

Last Used:      CURRENTLY      W/IN 12 MONTHS      W/IN 1-5YRS      MORE THAN 5YRS

**Family History:** *What is the age and state of health of your blood relatives? If deceased, what was their age at the time of death and any other major medical conditions?*

**Father:** LIVING    DECEASED    Age: \_\_\_\_\_    Medical Conditions: \_\_\_\_\_    Cause of Death: \_\_\_\_\_

**Mother:** LIVING    DECEASED    Age: \_\_\_\_\_    Medical Conditions: \_\_\_\_\_    Cause of Death: \_\_\_\_\_

**Brothers:** LIVING    DECEASED    Age: \_\_\_\_\_    Medical Conditions: \_\_\_\_\_    Cause of Death: \_\_\_\_\_

LIVING    DECEASED    Age: \_\_\_\_\_    Medical Conditions: \_\_\_\_\_    Cause of Death: \_\_\_\_\_

**Sisters:** LIVING    DECEASED    Age: \_\_\_\_\_    Medical Conditions: \_\_\_\_\_    Cause of Death: \_\_\_\_\_

LIVING    DECEASED    Age: \_\_\_\_\_    Medical Conditions: \_\_\_\_\_    Cause of Death: \_\_\_\_\_

**Mother's Mother:** LIVING    DECEASED    Age: \_\_\_\_\_    Medical Conditions: \_\_\_\_\_    Cause of Death: \_\_\_\_\_

**Mother's Father:** LIVING    DECEASED    Age: \_\_\_\_\_    Medical Conditions: \_\_\_\_\_    Cause of Death: \_\_\_\_\_

**Father's Mother:** LIVING    DECEASED    Age: \_\_\_\_\_    Medical Conditions: \_\_\_\_\_    Cause of Death: \_\_\_\_\_

**Father's Father:** LIVING    DECEASED    Age: \_\_\_\_\_    Medical Conditions: \_\_\_\_\_    Cause of Death: \_\_\_\_\_

**Family history of (circle all that apply):**    Cancer/Type: \_\_\_\_\_    Diabetes    Heart Disease    High Blood Pressure

Liver Disease    Stroke    Prostate Problems    Depression    Kidney Stones    Other: \_\_\_\_\_

If you have had any of these problems, please circle YES.

|                                    |     |
|------------------------------------|-----|
| <b>CONSTITUTIONAL/GENERAL</b>      |     |
| FEVER                              | YES |
| WEIGHT LOSS                        | YES |
| LOSS OF ENERGY                     | YES |
| DIFFICULTY SLEEPING                | YES |
| <b>HEAD AND NECK</b>               |     |
| BLURRED/DOUBLE VISION              | YES |
| TEMPORARY BLINDNESS                | YES |
| DIFFICULTY SWALLOWING              | YES |
| DIFFICULTY SMELLING                | YES |
| SORES IN MOUTH OR THROAT           | YES |
| LUMPS IN NECK                      | YES |
| EAR INFECTIONS                     | YES |
| <b>CARDIOVASCULAR</b>              |     |
| SHORT OF BREATH ON EXERTION        | YES |
| IRREGULAR HEART BEAT               | YES |
| CHEST PAIN                         | YES |
| LEG PAIN WITH EXERTION             | YES |
| HEART ATTACK                       | YES |
| STROKE                             | YES |
| AWAKING AT NIGHT SHORT OF BREATH   | YES |
| SWELLING IN ANKLES                 | YES |
| <b>RESPIRATORY</b>                 |     |
| CHRONIC COUGH                      | YES |
| COUGHING UP BLOOD                  | YES |
| SHORTNESS OF BREATH AT REST        | YES |
| WHEEZING                           | YES |
| HISTORY OF PNEUMONIA OR BRONCHITIS | YES |
| <b>GASTROINTESTINAL</b>            |     |
| FOOD INTOLERANCE                   | YES |
| INDIGESTION/HEARTBURN              | YES |
| VOMITING BLOOD                     | YES |
| JAUNDICE (YELLOW SKIN/EYES)        | YES |
| CHRONIC DIARRHEA                   | YES |
| CHRONIC CONSTIPATION               | YES |
| BLOOD IN STOOLS                    | YES |
| BLACK OR TARRY STOOLS              | YES |
| STOMACH OR INTESTINAL ULCERS       | YES |
| HISTORY OF H. PYLORI INFECTION     | YES |
| <b>HEMATOLOGIC</b>                 |     |
| EASY BRUISING                      | YES |
| BLEEDING TENDENCY                  | YES |
| ANEMIA                             | YES |
| ON BLOOD THINNERS                  | YES |
| SEASONAL ALLERGIES                 | YES |
| <b>MUSCULOSKELETAL</b>             |     |
| PAIN IN JOINTS OR BACK             | YES |
| SWELLING/EFFUSION IN JOINTS        | YES |
| STEROID SHOTS IN JOINTS/BACK       | YES |

|                                    |     |
|------------------------------------|-----|
| <b>GENITOURINARY**</b>             |     |
| BLOOD IN URINE                     | YES |
| KIDNEY OR BLADDER STONES           | YES |
| KIDNEY / BLADDER INFECTIONS        | YES |
| GONORRHEA, SYPHILIS/CHLAMYDIA      | YES |
| LOSS OF BOWEL OR BLADDER CONTROL   | YES |
| PAIN OR BURNING W/URINATION        | YES |
| LEAK URINE WHEN COUGH/SNEEZE       | YES |
| PROBLEMS W/FERTILITY               | YES |
| WEAK URINARY STREAM                | YES |
| INCOMPLETE BLADDER EMPTYING        | YES |
| INTERMITTENT STREAM                | YES |
| STRAINING TO URINATE               | YES |
| URINARY URGENCY                    | YES |
| HAVING TO URINATE AT NIGHT         | YES |
| <u>IF MALE:</u>                    |     |
| PROSTATE INFECTION                 | YES |
| PENILE/URETHRAL DISCHARGE          | YES |
| TESTIS OR SCROTAL INFECTION        | YES |
| SWELLING IN SCROTUM                | YES |
| PROBLEM W/ERECTIONS                | YES |
| BLOOD IN EJACULATE (SEMEN)         | YES |
| <u>IF FEMALE:</u>                  |     |
| ABNORMAL PAP SMEAR                 | YES |
| PAIN W/INTERCOURSE                 | YES |
| FREQUENT VAGINAL INFECTIONS        | YES |
| VAGINAL DRYNESS                    | YES |
| HOT FLASHES                        | YES |
| HISTORY OF PID OR TUBAL INFECTION  | YES |
| <b>SKIN/BREAST</b>                 |     |
| LUMPS IN BREAST                    | YES |
| NIPPLE DISCHARGE                   | YES |
| PAIN IN BREAST                     | YES |
| <b>NEURO</b>                       |     |
| WEAKNESS IN EXTREMITIES            | YES |
| NUMBNESS IN EXTREMITIES            | YES |
| PAIN SHOOTING DOWN EXTREMITIES     | YES |
| SEIZURES                           | YES |
| VERTIGO (DIZZINESS)                | YES |
| CHRONIC DEPRESSION                 | YES |
| UNCONTROLLED ANXIETY/PANIC ATTACKS | YES |
| <b>ENDOCRINE</b>                   |     |
| TEMPERATURE INTOLERANCE            | YES |
| EXCESSIVE THIRST                   | YES |
| THYROID PROBLEMS                   | YES |
| STEROID THERAPY                    | YES |

**Patient Name:** \_\_\_\_\_

**Date Completed:** \_\_\_\_\_

**VOIDING SYMPTOM SCORE**

|   |   | Not at all | Less than 1 time in 5 | Less than half the time | About half the time | More than half the time | Almost always | Your Score |
|---|---|------------|-----------------------|-------------------------|---------------------|-------------------------|---------------|------------|
| <b>1</b>  | <b>Incomplete Emptying.</b><br>Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?                      | 0          | 1                     | 2                       | 3                   | 4                       | 5             |            |
| <b>2</b>  | <b>Frequency.</b><br>Over the past month, how often have you had to urinate again less than two hours after you finished urinating?   | 0          | 1                     | 2                       | 3                   | 4                       | 5             |            |
| <b>3</b>  | <b>Intermittency.</b><br>Over the past month, how often have you found you stopped and started again several times when you urinated?   | 0          | 1                     | 2                       | 3                   | 4                       | 5             |            |
| <b>4</b>  | <b>Urgency.</b><br>Over the past month, how often have you found it difficult to postpone urination?  | 0          | 1                     | 2                       | 3                   | 4                       | 5             |            |
| <b>5</b>  | <b>Weak Stream.</b><br>Over the past month, how often have you had a weak urinary stream?   | 0          | 1                     | 2                       | 3                   | 4                       | 5             |            |
| <b>6</b>  | <b>Straining.</b><br>Over the past month, how often have you had to push or strain to begin urinating?  | 0          | 1                     | 2                       | 3                   | 4                       | 5             |            |
|   |   | None       | 1 time                | 2 times                 | 3 times             | 4 times                 | 5+            |            |
| <b>7</b>  | <b>Nocturia.</b><br>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          | 1                     | 2                       | 3                   | 4                       | 5             |            |
| (Please add your above scores)  |   |            |                       |                         |                     |                         |               |            |
| <b>Total I-PSS Score:</b>   |   |            |                       |                         |                     |                         |               |            |
| <b>Quality of Life due to Urinary Symptoms</b>  |   | Delighted  | Pleased               | Mostly Satisfied        | Mixed               | Mostly Dissatisfied     | Unhappy       | Terrible   |
| If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? |   | 0          | 1                     | 2                       | 3                   | 4                       | 5             | 6          |

## **CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

### **Use and Disclosure of Your Protected Health Information (PHI)**

Your protected health information will be used by Urology Specialists of Nevada or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

### **Notice of Privacy Practices**

This acknowledges your receipt and reading of USON's: Notice of Privacy Practices. You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You should review the notice prior to signing this consent.

### **Requesting a Restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your protected health information.

USON may or may not agree to restrict the use or disclosure of your protected health information.

If USON agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

### **Reservation of Right to Change Privacy Practices**

USON reserves the right to modify the privacy practices outlined in this notice.

### **Signature**

I have reviewed this consent form and give my permission to USON to use and disclose my health information in accordance with it.

---

Name of Patient (Print or Type)

---

Signature of Patient

---

Date

---

Signature of Patient Representative

---

Relationship of Patient Representative to Patient

**AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS OR SELECTED PERSONAL CAREGIVERS**

**INFORMATION to Be Used or Disclosed**

The information covered by this authorization includes:

All medical records and billing information and Protected Health Information

**Persons Authorized to Use or Disclose Information**

Information listed above will be used or disclosed by:

**Urology Specialists of Nevada**

**Persons to Whom Information May be Disclosed**

Information described above may be disclosed to:

Authorization to disclose Protected Health Information to selected family members:

|    |       |       |          |
|----|-------|-------|----------|
| 1. | _____ | _____ | _____    |
|    | Name  | Date  | Initials |
| 2. | _____ | _____ | _____    |
|    | Name  | Date  | Initials |
| 3. | _____ | _____ | _____    |
|    | Name  | Date  | Initials |
| 4. | _____ | _____ | _____    |
|    | Name  | Date  | Initials |
| 5. | _____ | _____ | _____    |
|    | Name  | Date  | Initials |
| 6. | _____ | _____ | _____    |
|    | Name  | Date  | Initials |

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to Urology Specialists of Nevada. You should contact the Privacy Official to terminate this authorization.

**Potential for Re-disclosure**

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

**Signature**

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative

\_\_\_\_\_  
Relationship of Patient Representative to Patient