

The Urology Center, P.C.

PATIENT INFORMATION

Patient Name: _____
Male Female

Address: _____

Home Phone: _____
Ok to leave a message Yes or No

Work Phone: _____
Ok to leave a message Yes or No

Cell Phone: _____
Ok to leave a message Yes or No

Date of Birth: _____

Social Security Number: _____

Referring Dr: _____

Family Dr: _____

Spouse/Parent: _____

PERMISSION TO RELEASE INFORMATION

TO: Spouse

Other: Name: _____

Emergency

Contact: _____

Emergency Phone: _____

INSURANCE INFORMATION

Primary

Insured's Name Date of Birth Insured's Employer, Employer Address & Phone Number

Secondary

Insured's Name Date of Birth Insured's Employer, Employer Address & Phone Number

Date

RESPONSIBLE PARTY INFORMATION

Guarantor: _____

Address: _____

Home Phone: _____

Work Phone: _____

EMPLOYER INFORMATION

Employer Name: _____

Employer Address: _____

Employer Phone: _____

DO YOU HAVE ANY KNOWN ALLERGIES?

Yes No

LIST KNOWN ALLERGIES:

AMERICAN RECOVERY AND REINVESTMENT ACT, ENACTED February 2009

Preferred Language: _____

- Race: American Indian or Alaska Native
 Black or African American
 Caucasian
 Asian
 Native Hawaiian or Other Pacific Islander
 Other

Ethnicity: Hispanic or Latino
 Not Hispanic or Latino

The Urology Center, P.C. – Authorization Form

A. Notice of Privacy Practices

The Policies and Procedures of The Urology Center, P.C. are designed to comply with the Health Insurance Portability and Accountability Act of 1996. The Urology Center, P.C. will release your protected health information to your doctors, hospitals or insurance companies for treatment, payment and operation. The Urology Center, P.C. Notice of Privacy Practices are posted in the reception area and are available at the front desk.

B. Authorization To Treat

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving laboratory, pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

C. Assign of Insurance Benefits

I hereby assign all medical and /or surgical health insurance benefits, to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance.

D. Patient Rights and Responsibilities

The Urology Center, P.C. has established a Patient's Bill of Rights, I agree that I have received and understand my rights as a patient.

E. Advance Directive

Regardless of any advance directives set forth in a living will, health care power of attorney or other written statement, any unexpected medical emergency, in this facility, will be managed with resuscitative or other stabilizing measures followed by a transfer to a hospital's emergency department.

F. Disclosure of Ownership

The Urology Center, P.C. including our Ambulatory Surgery Center, is owned and operated by Drs. Konigsberg, Kroeger, Gordon, Morton, Koukol, Longo, Lim, Jepson, Leu, Donovan and Hill. Any services that you receive at this location are a part of the operations of The Urology Center, P.C.

G. Medicare Coordination of Benefits Assessment

Medicare requires that we ask the following questions of all our patients so that we can comply with Medicare rules and regulations. We appreciate your time in completing these questions.

- | | | | |
|--|------------|-----------|-----------|
| 1. Are you or your spouse currently employed? | YES | OR | NO |
| If yes then: | | | |
| Do you have group health coverage based on your own or a spouse's current employment? | YES | OR | NO |
| 2. Are you entitled to Medicare because of disability or End Stage Renal Disease? | YES | OR | NO |
| 3. Is this illness or injury the result of an automobile accident or other injury? | YES | OR | NO |
| 4. Is this illness or injury the result of an accident or illness that occurred at work: | YES | OR | NO |
| 5. Has treatment and payment for this accident or illness been authorized by the Veteran's Administration? | YES | OR | NO |
| 6. Are you entitled to any benefits under the Federal Black Lung Program? | YES | OR | NO |

The undersigned patient or patient's guardian hereby acknowledge that I have read, understand and agree to conditions set forth in the:

- A. Notice of Privacy Practices
- B. Authorization to Treat
- C. Assignment of Benefits
- D. Patient Rights and Responsibilities
- E. Advance Directive
- F. Disclosure of Ownership

As a Medicare recipient, if applicable, I have completed Section G accurately and to the best of my ability.

Printed Patient Name

Account Number

Signature

Date

Urology Center, P.C.

Patient History Form

Date: _____

Date of Birth: _____

Name: _____

Age: _____

Past Medical History

Please check any illnesses you have or have had in the past:

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Neurogenic Bladder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Degenerative Lumbar Disk Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Benign Prostatic Hypertrophy (BPH)
or Enlarged Prostate | <input type="checkbox"/> Dementia/Alzheimers | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Depression | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Bleeding Tendency Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Cancer – Bladder | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cancer – Breast | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Cancer – Cervical | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Radiation Cystitis |
| <input type="checkbox"/> Cancer – Colon | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Renal Insufficiency |
| <input type="checkbox"/> Cancer – Esophageal | <input type="checkbox"/> GERD/Acid Reflux | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cancer – Kidney | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Spina Bifida or
Myelomeningocele |
| <input type="checkbox"/> Cancer - Leukemia/Lymphoma | <input type="checkbox"/> Gout | <input type="checkbox"/> STD |
| <input type="checkbox"/> Cancer – Lung | <input type="checkbox"/> Heart Attack/MI | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer – Other | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer – Prostate | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Transient Ischemic Attack |
| <input type="checkbox"/> Cancer – Skin | <input type="checkbox"/> High Blood Pressure/Hypertension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer – Testicular | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Urethral Stricture Disease |
| <input type="checkbox"/> Cancer – Uterine | <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Valvular Heart Disease or
Heart Murmur |
| <input type="checkbox"/> Cardiac Arrhythmia | <input type="checkbox"/> Interstitial Cystitis | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Irritable Bowel Syndrome | |
| <input type="checkbox"/> Chron's/Ulcerative Colitis | <input type="checkbox"/> Kidney Infection | |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Liver disease/Jaundice | |
| | <input type="checkbox"/> MRSA | Other: _____ |

Past Surgical History

Please list all of your previous operations and hospitalizations. Give dates and locations if known.

Have you had a medicated cardiac stent placed in the last 12 months? _____ **If yes when?** _____
If female, how many pregnancies have you had? _____ **How many miscarriages?** _____

Family History

Please check each medical concern that has occurred in your blood relatives:

DISEASE	Father	Mother	Sister	Brother		Father	Mother	Sister	Brother
Diabetes					High Blood Pressure				
Kidney Disease					Heart Disease				
Kidney Stones					Bedwetting				
Cancer					Nervous Disorder				
Bleeding Tendency					Stroke				
					Tuberculosis				

Is your father alive? ___ Yes ___ No **Age/Age at death:** ___ **Present Health/Cause of Death** _____

Is your mother alive? ___ Yes ___ No **Age/Age at death:** ___ **Present Health/Cause of Death** _____

If you are a male, do you have any relatives who have had prostate cancer? ___ Yes ___ No

If so, which relatives? ___ Father ___ Brother(s) ___ Other _____

If you know of any other medical conditions that run in your family, please list them here:

PLEASE COMPLETE THE QUESTIONS ON THE BACK OF THIS FORM.

Name: _____

Social Habits History

Do you smoke cigarettes? ___ Yes ___ No If yes, how many packs per day? ___ For how long? _____

Did you smoke cigarettes previously and quit? ___ Yes ___ No If yes, how many packs per day? ___ For how long? _____ When did you quit? _____

Do you use any other form of tobacco? ___ Yes ___ No If yes, what kind? _____

Do you drink alcohol? ___ Yes ___ No If yes, how much do you drink in an average week? _____

Do you drink caffeine? ___ Yes ___ No If yes, how many per day? _____

Do you use any other drugs? ___ Yes ___ No If yes, what kind? _____

Allergies

<u>Medication</u>	<u>Reaction</u>	<u>Medication</u>	<u>Reaction</u>
___ Sulfa	_____	Other: _____	_____
___ Penicillin	_____	Other: _____	_____
___ Iodine (IV Contrast/Dye)	_____	Other: _____	_____
___ Latex	_____	Other: _____	_____
Other: _____	_____	Other: _____	_____
Other: _____	_____	Other: _____	_____

Other (Please Specify): _____

No Drug Allergies _____

Medications

Please bring your current medication list to every visit to The Urology Center PC

Please list or attach a list of all the medications you are currently taking, including prescription, over the counter and herbal supplements:

Drug, medication or herbal	How often taken	Dosage (mg, mcg, IU, ect.)

Your local Pharmacy: _____

Your mail order Pharmacy: _____

Height and Weight

Height: _____

Weight: _____

Name: _____

Date of Birth: _____

Chief Complaint

What is the main reason you came to the Urology Center at this time? _____

Urologic Symptoms

Please check symptoms you have now:

- | | |
|---|--|
| <input type="checkbox"/> blood in urine | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> burning or pain with urination | <input type="checkbox"/> phimosis |
| <input type="checkbox"/> change in voiding habits | <input type="checkbox"/> slow urinary stream |
| <input type="checkbox"/> dysuria | <input type="checkbox"/> stress incontinence |
| <input type="checkbox"/> flank pain | <input type="checkbox"/> trouble starting stream |
| <input type="checkbox"/> frequent urination - daytime | <input type="checkbox"/> trouble with erections |
| <input type="checkbox"/> frequent urination - night | <input type="checkbox"/> urethral discharge |
| <input type="checkbox"/> incomplete bladder emptying | <input type="checkbox"/> urgency |
| | <input type="checkbox"/> vaginal discharge |

Review

Reviewed by: _____ M.D. Date: _____

THE VOIDING DIARY

The voiding diary is a tool utilized to help our office assist those patients who experience wetting (enuresis) and/or urinary tract infections.

Many children are troubled by uncontrolled wetting (enuresis), whether it occurs during the day or at night. We understand such problems can unsettle the whole family. Very often, a wetting problem disrupts the child's social life, home situation, and school work.

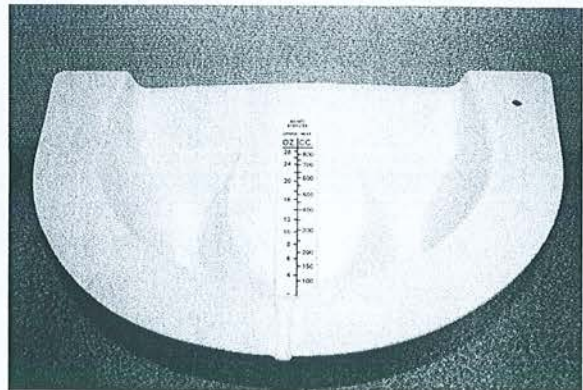
We are here to help. Often, the wetting problems of children are attributed exclusively to psychological causes. We have found that often there is a physical cause for the wetting problem. For example, the problem might be caused by a birth defect of the urinary tract. If correctly diagnosed, such a problem can be corrected surgically. In other cases, the problem might be solved through the use of medication, diet, or a combination of approaches.

Your pediatrician has recognized the importance of complete and accurate diagnosis. It will be determined whether your child's problem is caused by a birth defect, bladder dysfunction, emotional/social issues, or a combination of these factors, using the following approach:

STEP 1: Voiding Diary. Evaluation of your child begins at home. Please complete the diary and return to us.

The Voiding Diary – This diary will be used to ascertain your child's functional bladder capacity. This capacity will be compared to the predicted normal bladder capacity for your child's age. The diary will provide a framework upon which our evaluation and treatment will be based. It is important to keep accurate records.

Please perform the measurements in a "Specipan" which is also referred to as a "Texas Hat". (See photo). This may be obtained from a local pharmacy, hospital supply store, or through your pediatrician. Other containers are also acceptable. As children also are constipated, please log when bowel movements occur and if they are unusually large or small and/or hard or soft. The diary should be kept for five (5) days (which do not need to be consecutive). If your child attends school, the weekends are good times to obtain the measurements.



To measure, place container on toilet under seat.

Use the *Voiding Record Diary* enclosed. Start measuring the first time your child voids in the morning. Write down the time and the amount (in ounces or cc's) your child has voided. If you know what time the wetting occurs during the night, please write that down also. Please do not encourage your child to use the bathroom; allow him to void as usual.

STEP 2: Urologic history, physical examination, flow rate and urinalysis. You should prepare your child to enable him to participate in talking to a doctor about the wetting problem, to permit a doctor to examine the abdomen, genitalia, anus and lower extremities, and to allow an ultrasound of the abdomen if necessary. The tests we perform are painless.

Based on the results of this evaluation, a working diagnosis will be formulated and a treatment will follow. Some children require further testing before a treatment plan is suggested.

STEP 3: Working diagnosis – Incontinence. Incontinence is wetting related to a structural problem of the urinary tract. If incontinence is suspected, we would likely suggest x-rays such as an intravenous pyelogram (IVP) and/or voiding cystogram (VCUG). Should a problem be found, surgery may be required to correct the wetting. Should corrective surgery alone not improve continence, an enuresis treatment program would be provided. About 10% of children seen need surgery to correct their wetting problem.

STEP 4: Working diagnosis – Enuresis. Enuresis is wetting which occurs without a structural problem of the urinary tract. If we suspect enuresis, an enuresis treatment program will be set up.

Enuresis Treatment Program – we draw from 11 treatment modalities to treat children with enuresis. These modalities include psychological techniques (positive reinforcement, urine alarm, child/family therapy, dry bed training, dry pants trainings, ect.), bladder medication, elimination diet, control of constipation, creams to treat vaginal problems, and/or intermittent catheterization of the bladder.

We allow 12 weeks of treatment using the enuresis program before pursuing further avenues. If wetting has not remarkably improved after 12 weeks of treatment, further urodynamic testing and/or psychological interviewing may be recommended. Based on results of the testing, a combination of corrective surgery, dry beds or dry pants training, pharmacotherapy or psychotherapy will be suggested. If relapses of wetting occur, either further testing will be suggested or the enuresis treatment program will be reinstated.

Name _____

DOB _____

VOIDING RECORD
DIARY

DATE/TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
7 a.m.					
8 a.m.					
9 a.m.					
10 a.m.					
11 a.m.					
12 noon					
1 p.m.					
2 p.m.					
3 p.m.					
4 p.m.					
5 p.m.					
6 p.m.					
7 p.m.					
8 p.m.					
9 p.m.					
10 p.m.					
11 p.m.					
Overnight					

Please mark: "V" for each void and include volume of urine measured

"BM" for each bowel movement

"A" for urine accident

"S" for bowel accident