New Patient Information

Which Physician will you be seeing today?____

How did you hear about our practice? ____

Name ____ Preferred ______________ Age: ________

Last First MI

Date of Birth: ____________ Sex: _____ Social Security #: __________________ Marital Status: __________

Race: Check one: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

Ethnicity: Check One: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Primary Language: ________________

Address: ____

City State Zip Code

Home# ____________________ Work #: ______________________ Cell #: _________________________

Preferred Communication: (Check One) ☐ Home ☐ Cell ☐ Work ☐ Email

Email Address: ________________________________ Employer Name: __________________________

Referring Physician: ______________________________________ Phone: ______________________

Primary Care Physician: ___________________________________ Phone: ______________________

Emergency Contact: _______________________________________ Phone: ______________________

Information of Spouse (or Parent if Minor):

Name: ________________________________ Address: ______________________________________

Phone #: ______________________ Work: _____________________ Cell: ________________________

Spouse/Parent Date of Birth: ______________________ Social Security#: _________________________

Employer: ___________________________________

Primary Insurance Company: ____ Phone: ________________

Insured's SS# __________________________ Policy Holder's Date of Birth: __________________________

Secondary Insurance Company: ______________________________________ Phone: ________________

Insured's SS# __________________________ Policy Holder's Date of Birth: __________________________

Initial Each Line and Sign Below:

_____ I authorize Lowcountry Urology Clinics, PA to release medical records to other physicians relating to my treatment and care.

_____ INSURANCE AUTHORIZATION AND ASSIGNMENT: I hereby authorize Lowcountry Urology Clinics, PA to furnish information to insurance carriers concerning my illness and treatment(s) and hereby assign to the physician all payment(s) for medical services rendered to myself or my dependents. I further understand that I am responsible for any balance not covered by insurance.

_____ I understand it is my responsibility to obtain insurance referrals from my primary care physician if required by my insurance.

____ ____________________

Signature of Patient or Authorized Person Date

Today's Date:____________ Patient Name:____

Reason for Visit:____ Date of Birth:________________

Local Pharmacy Name:____________________________________ Pharmacy Phone #:________________

Pharmacy Location/Address:____

Past Medical History (PMHx) Please Check All that Apply

____Anxiety
____Arthritis- **Please Circle**
- Osteoarthritis
- Psoriatic
- Rheumatoid

____Cancer - type: _________________
____Coronary Artery Disease (CAD)
____Degenerative Disc Disease
____Depression
____Diabetes (High Blood Sugar)
____Heart Disease
____High Cholesterol
____High Blood Pressure
____Irritable Bowel Syndrome
____Low Thyroid
____High Thyroid
____Chronic Obstructive Pulmonary Disease (COPD)
____Seizure
____HIV/Aids

Urologic History:

____Abdominal Pain
____Back Pain
____Bladder Displacement
____Blood in Urine
____Burning
____BPH
____Difficult Voiding
____Elevated PSA
____Erectile Dysfunction
____Incontinence
____Kidney Disease
____Kidney Stones
____Waking to Urinate @ night/times ____
____Overactive Bladder
____Prostate Cancer
____Prostatitis
____Renal Failure
____Urinary Frequency
____Urinary Tract Infection (UTI)
____Urinary Retention
____Urinary Urgency
____Vaginal Discharge

List Any Other Below: ________________________________
____
____

Past Surgical History (PSHx)

Surgery/Date of Surgery:

____
____
____
____
____
____
____
____

Please be sure to list the dates for each surgery if there is more than one.

Review of Systems

Do you now or have you had any problems relating to these systems?
Please circle "Y' for Yes and "N" for No

Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Headches	Yes	No
Other		

Eyes

Blurred Vision	Yes	No
Double Vision	Yes	No
Pain	Yes	No
Other		

Ear/Nose/Throat/Mouth

Ear Infection	Yes	No
Sore Throat	Yes	No
Sinus Problems	Yes	No
Other		

Cardiovascular

Chest Pain	Yes	No
Varicose Veins	Yes	No
High Blood Pressure	Yes	No
Other		

Respiratory

Wheezing	Yes	No
Frequent Cough	Yes	No
Shortness of Breath	Yes	No
Other		

Gastrointestinal

Abdomen Pain	Yes	No
Nausea/Vomiting	Yes	No
Indigestion/Heartburn	Yes	No
Other		

Genitourinary

Urine Retention	Yes	No
Painful Urination	Yes	No
Urinary Frequency	Yes	No
Other		

Integumentary

Skin Rash	Yes	No
Boils	Yes	No
Persistent Itch	Yes	No
Other		

Neurological

Tremors	Yes	No
Dizzy Spells	Yes	No
Numbness/Tingling	Yes	No
Other		

Musculoskeletal

Joint Pain	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No
Other		

Endocrine

Excessive Thirst	Yes	No
Too hot/cold	Yes	No
Tired/Sluggish	Yes	No
Other		

Psychologic

Are you satisfied with your life?	Yes	No
Do you feel severely depressed?	Yes	No
Have you ever considered suicide?	Yes	No

Hematological/Lymphatic

Swollen Glands	Yes	No
Blood Clotting	Yes	No
Other		

Allergic/Immunologic

Hay Fever	Yes	No
Drug Allergies	Yes	No
Other		

Physician Use Only:

Physician:____________________ **Date:**__________

Medication List (Meds) Please List All Below

Drug	Dosage	Frequency	Reason for Medication

Allergies to Medications: ☐ Yes ☐ No

If yes, please explain:____

Food Allergies? ☐ Yes ☐ No

If yes, please explain:____

Allergic to Latex? ☐ Yes ☐ No

Any other know Allergies? Please Explain:

____

____

____

Family Medical History (FMHx) List relative(s) with history of illness

Diabetes ___

Heart Disease ___

High Blood Pressure ___

Kidney Disease ___

Vascular Disease ___

Prostate Cancer ___

Stroke ___

Other ___

Social History (SHx)

Alcohol Use: ☐ Never ☐ Current ☐ Former ____ # of drinks per day

Age started: ________ Age Stopped: _________

Tobacco Use: ☐ Never ☐ Current ☐ Former ____ # of packs/cigarettes per day

Age started: ________ Age Stopped: _________

Drug Use: Do you use recreational drugs? ☐ Yes ☐ No

If yes, explain:

___

___

Occupation: ___ Number of Children: ___

Physician Notes:

___

___

___

___

___

___

___

___

Family Cancer History Form
Risk Assessment for Hereditary Cancer Testing

Patient Name	
Date of Birth	
Provider Name	
Date of Service	

1st, 2nd, or 3rd degree relatives	Parents, siblings, children, aunts, uncles, first cousins, nieces, nephews
Reimbursement Criteria	Metastatic prostate cancer
	Known genetic mutation in the family Metastatic prostate cancer
	Prostate cancer Gleason ≥ 7 AND one or more 1st, 2nd, or 3rd degree relatives with breast cancer < 50 or ovarian cancer at any age
	Two or more 1st, 2nd, or 3rd degree relatives with any of the following: Breast, pancreatic or prostate (Gleason ≥ 7 or metastatic) cancer at any age

Instructions: Please indicate cancer history of patient and 1st, 2nd, or 3rd degree relatives.

Cancer Diagnosis	Yes	No	Relationship to You	Age at Diagnosis
Metastatic Prostate Cancer				
Prostate Cancer (Gleason ≥ 7)				
Breast Cancer				
Ovarian Cancer				
Pancreatic Cancer				

Instructions: Please indicate genetic mutation history of patient and 1st, 2nd, or 3rd degree relatives.

Genetic Mutation Type	Yes	No	Relationship to You	Age of Diagnosis

For Office Use Only:

Order Genetic Testing	☐ Yes ☐ No
Provider Signature	

LOWCOUNTRY
UROLOGY CLINICS
www.lowcountryurology.com

Receipt of Notice of Privacy Practices
Written Acknowledgement/Authorization

HIPAA Notices of Privacy Practices Acknowledgement
I have received, read, and understand the Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of the practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Initial here: ____________

Authorization to Release and/or Obtain Medical Records
I hereby authorize all physicians participating in my healthcare and Lowcountry Urology Clinics, PA the release, use, and disclosure of my entire medical record by mail, phone, fax, and to carry out my treatment, payment, and healthcare operations.

Signature required: ____

Authorized Methods of Communication:

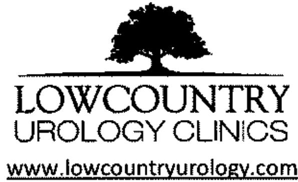
1. Okay to leave a detailed message on answering machine/voicemail? Yes ________ No ________
2. Preferred phone number (please check one): Home _______ Cell _______ Work _______
3. Please list anyone authorized to access your medical records, treatment details, and/or appointment info:

Name	Relationship	Phone

I understand that the authorization for release of information will be valid for one year from the date of this signature and can only be revoked upon written notice. By signing below, I acknowledge that this form has been read in full and explained as necessary.

____ ____________________
Signature of Patient or Personal Representative Date

____ ____________________
Patient Name (Please Print) Date of Birth



www.lowcountryurology.com

Lowcountry Urology Clinics, PA is committed to providing you with the best possible medical care. Our practice participates with a variety of insurance plans. As a courtesy to our patients we submit all charges to the appropriate insurance companies and will do our best to answer any questions you may have. Specific coverage issues, however, should be directed to your insurance company.

It is your responsibility to:

- Bring your current insurance card to every visit. We consider an insurance card similar to a credit card because you are asking us to bill another party for the services you have been provided. If you do not bring your insurance card you should be prepared to pay for your services in full at the time of service.
- Be prepared to pay your copay at each visit. We are required by your insurance plan to collect copays on the date of service. If you do not bring proper payment to your visit you may be required to reschedule your appointment, except in the case of a medical emergency.
- Pay for self-pay services or any services/amounts not paid by insurance at the time of service. All non-covered services, as well as coinsurances and deductibles, are to be paid at check-in. Self-pay services are to be paid for up front at the time of service. For your convenience, we accept cash, check, Visa, MasterCard, Discover and Care Credit.
- Pay in advance for surgical procedures. If your physician recommends a surgical procedure you will be required to pay your portion of the fees in advance of the procedure. We will communicate with your insurance company to obtain authorization and benefit information.

Medicare Lifetime Signature on File (for Medicare patients)

I request that payment of authorized Medicare benefits be made on my behalf directly to this practice for any services furnished to me. I authorize the release of any medical or other information necessary for processing claims to the Center for Medicare and Medicaid Services.

Initial here: ___________________

Private Insurance Authorization for Assignment of Benefits/Information Release

I authorize the payment of medical benefits be made on my behalf directly to this practice for any services furnished to me. I understand that I am financially responsible for any amounts not covered by insurance contract. I authorize the release to my insurance company of any information concerning healthcare, advice, or treatment provided to me that is necessary for processing insurance claims.

Initial here: ___________________

Agreement of Financial Responsibility for Routine, Preventive, and Non-Covered Services

Routine and preventive services are not covered by most insurance plans. Your insurance plan may not cover your visit today if you do not have a medical complaint or significant problem/abnormality. In the event that services provided are denied as routine, preventive, pre-existing, or non-covered you will be responsible for the balance.

Initial here: ___________________

By signing below, I acknowledge that I have reviewed and understand the above practice policies.

_______________________________ _______________________

Signature of Patient or Personal Representative Date

_______________________________ _______________________

Patient Name (Please Print) Date of Birth