

New Patient Information

Which Physician will you be seeing today? _____

How did you hear about our practice? _____

Preferred Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Location/Address: _____

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: _____

Preferred Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Location/Address: _____

Past Medical History (PMHx)

- Anxiety
- Arthritis- **Please Circle**
 - Osteoarthritis
 - Psoriatic
 - Rheumatoid
- Cancer - type: _____
- Coronary Artery Disease (CAD)
- Degenerative Disc Disease
- Depression
- Diabetes (High Blood Sugar)

Please Check All that Apply

- Heart Disease
- High Cholesterol
- High Blood Pressure
- Irritable Bowel Syndrome
- Low Thyroid
- High Thyroid
- Chronic Obstructive Pulmonary Disease (COPD)
- Seizure
- HIV/Aids

Urologic History:

- | | |
|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Overactive Bladder |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Bladder Displacement | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Urinary Frequency |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Urinary Tract Infection (UTI) |
| <input type="checkbox"/> Difficult Voiding | <input type="checkbox"/> Urinary Retention |
| <input type="checkbox"/> Elevated PSA | <input type="checkbox"/> Urinary Urgency |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Incontinence | |
| <input type="checkbox"/> Kidney Disease | List Any Other Below: _____ |
| <input type="checkbox"/> Kidney Stones | _____ |
| <input type="checkbox"/> Waking to Urinate @ night/times _____ | _____ |

Past Surgical History (PSHx)

Surgery/Date of Surgery:

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

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 1 st , 2 nd , or 3 rd degree relatives with breast cancer < 50 or ovarian cancer at any age
	Two or more 1 st , 2 nd , or 3 rd 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Provider Signature	

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 _____

Integumentary

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

Eyes

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

Neurological

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

Ear/Nose/Throat/Mouth

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

Musculoskeletal

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

Cardiovascular

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

Endocrine

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

Respiratory

Wheezing Yes No
Frequent Cough Yes No
Shortness of Breath 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

Gastrointestinal

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

Hematological/Lymphatic

Swollen Glands Yes No
Blood Clotting Yes No
Other _____

Genitourinary

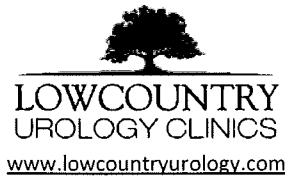
Urine Retention Yes No
Painful Urination Yes No
Urinary Frequency Yes No
Other _____

Allergic/Immunologic

Hay Fever Yes No
Drug Allergies Yes No
Other _____

Physician Use Only:

Physician: _____ Date: _____



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: _____

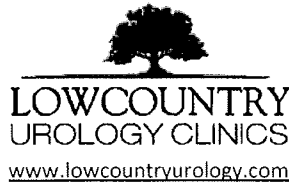
By signing below, I acknowledge that I have reviewed and understand the above practice policies.

 Signature of Patient or Personal Representative

 Date

 Patient Name (Please Print)

 Date of Birth



**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
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
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