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)

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.

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	

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:**_____

LOWCOUNTRY
UROLOGY CLINICS
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

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