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DATE: ___/___/____
MRN: _____

PATIENT REGISTRATION FORM
PLEASE PRINT & COMPLETE IN FULL (Black Ink Only Please)

PATIENT INFORMATION

Social Security #: ___ - ___ - ___ Date of Birth: _____ Age ____
Last Name: _____ First Name: _____ Middle: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: (___) - ___ - ___ Work Phone: (___) ___ - ___ - ___
Home Phone: (___) - ___ - ___ Sex: (circle) Female or Male

E-mail address: _____

☐ I give permission for Urology Associates, PC/WISH to leave messages on my voice mail.

Marital Status: (circle) Single Married Widowed Divorced Separated
Race: (circle) African American Asian Caucasian Hispanic Native American Other
Ethnicity: (circle) Hispanic Non-Hispanic Preferred Language: _____

EMPLOYER INFORMATION

Employed: Y or N Full Time Student ____ Part-time Student _____
Employer Name: _____
Main Office Phone: (___) - ___ - ___ Occupation: _____

INSURANCE INFORMATION (We Require A Copy Of Your Card)

Primary Insurance: _____
Policy Holder Name (If other than yourself): _____ Relationship: _____

Policy Holder Employer: _____
Policy Holder Social Security #: ___ - ___ - ___ Date of Birth: _____
Secondary Insurance: _____

REFERRED BY

Referring Physician: _____ Phone: (___) - ___ - ___

PRIMARY CARE PHYSICIAN

Primary Care Physician: _____ Phone: (___) - ___ - ___

EMERGENCY CONTACT

Name: _____ Relationship: _____
Cell Phone: (___) - ___ - ___ Work Phone: (___) - ___ - ___

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Billing Policy

Thank you for choosing Urology Associates, P.C. as your healthcare provider. Our providers and staff are committed to delivering service, compassion and quality care to you. Understanding our Financial Policy is an important part of our professional relationship.

Financial Policy

Your insurance co-payment* is due at the time of your visit. If you are unable to pay your co-payment at the time of your visit, we will reschedule your visit.

If we determine you have a deductible* or co-insurance* amount due, you will be asked to pay this amount at the time of your visit.

If you are required to obtain a referral from your primary care physician in order to see a urologist, it is your responsibility to bring this with you to your visit. If you do not have a referral, we will reschedule your visit so you can obtain one.

Urology Associates will assist in obtaining pre-certification from insurance plans if required. However, insurances vary in coverage, and it is the patient's responsibility to understand medical benefits and requirements. We recommend that the patient verifies insurance benefits for any procedures, tests or services scheduled.

It is your responsibility to know if we participate with your insurance plan. If your insurance company is out of network with us, you will be responsible for payment in full at the time of service.

You will be responsible for 100% of your total out of pocket* responsibility amount prior to any procedures, testing, or services.

For self-pay patients, 150.00 is due at check-in. A credit card on file is required for the remaining balance which is expected to be paid in full at check-out.

We do our best to estimate your financial responsibility up front, but please understand this is only an estimate.

Cancellation/No-Show/Reschedule Policy

In order to provide the best care and service to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your office appointment. If you forget or fail to show up for the appointment, there will be a $25.00* fee charged to your account. *$50.00 fee applies to **WISH** patients.

In addition, cancellation of a scheduled procedure requires 72 hour notice. Any cancellation not made 72 hours in advance will be subject to a fee of $150.00. A reschedule fee of $75.00 will be charged each time a procedure or surgery appointment is rescheduled.

The Cancellation/No-Show/Reschedule fees will not be billed to insurance.

Signature of Patient or Guardian:_____ Date:_____

Helpful definitions*

Out of pocket. Costs you have to pay yourself.

Copayment (or copay). Fixed amount you pay at each visit for services such as an office visit. (You pay your copay at the time of service, even if you have met your deductible, until you meet your out-of-pocket maximum.)

Deductible. The yearly amount you must pay before your insurance begins to pay.

Coinsurance. The percentage you pay for care even after your deductible is paid in full.

Out-of-pocket maximum. The most money you will pay in one year for all covered services. This usually includes all out-of-pocket costs: copayments, deductible, and coinsurance.

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Patient MRN: _____
Provider: _____
Date: _____

New Patient Form

Name: _____
Date of Birth: _____

Pharmacy Name: _____
Pharmacy Number & Location: _____
_____

Please, list your medical providers below:
OB/GYN: _____
PCP: _____
Urologist: _____
Other: _____
Who referred you to WISH? _____

PRESENTING PROBLEM (What is you reason for visiting the Women's Institute?): _____
_____

MEDICATIONS (Please, list all current medications & dosages including vitamins, minerals, & herbs.)

_____

_____

Medications allergies: _____
Seasonal allergies: _____

SURGICAL HISTORY **Please, list type & date.**

_____

_____

PAST MEDICAL HISTORY (Please, check all that apply to you, currently or previously.)

- ❑ Anemia
- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Back or Pelvic Injury
- ❑ Blood Clots
- ❑ Cancer (please specify)
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticulosis
- ❑ Endometriosis
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Interstitial Cystitis
- ❑ Irritable Bowel Syndrome
- ❑ Kidney Disease/Stones
- ❑ Migraine Headaches
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Ovarian Cysts/Uterine Fibroids
- ❑ Sexually Transmitted Infections
- ❑ Stroke
- ❑ Thyroid Disorder
- ❑ UTI (recurrent)

Additional: _____

FAMILY HISTORY (Please, check all that apply to your immediate family)

- ❑ Anemia
- ❑ Anxiety Disorder
- ❑ Asthma
- ❑ Blood Clots
- ❑ Breast Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Interstitial Cystitis
- ❑ Irritable Bowel Syndrome
- ❑ Kidney Disease/Stones
- ❑ Migraine Headaches
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Ovarian Cancer
- ❑ Pancreatic Cancer
- ❑ Prostate Cancer
- ❑ Stroke
- ❑ Thyroid Cancer
- ❑ Other Cancer _____

_____
_____

Additional: _____

FLUID INTAKE PATTERN (Please, list the amount of each type of beverage consumed in a typical day)

Water _____/day Non-caffeinated drinks (juice/milk) _____/day Caffeinated drinks _____/day
What caffeinated and non-caffeinated drinks do you typically consume? _____

How would you feel if you had to live with your current **urological** problem the way it is now, no better, no worse, for the rest of your life?
(*If applicable, please circle the number that best reflects your feelings about the current problem we are seeing you for today.)*

Delighted 	Pleased 	Mostly Satisfied	Mixed 	Mostly Dissatisfied	Unhappy 	Terrible 
0	1	2	3	4	5	6

SOCIAL HISTORY

□ Single □ Married____/yrs □ Separated □ Divorced □ Widowed
Do you consider yourself: □ Heterosexual □ Homosexual □ Bisexual

History of tobacco use? Yes _____ No _____ If yes, when did you quit? _____
Do you currently use tobacco? Yes _____ No _____ If yes, type/amount per day? _____
Alcoholic beverage intake: None _____ Occasional _____ Moderate _____ Heavy _____ …. Beer _____ Liquor _____ Wine _____
Illicit street drug use? _____ Do you have a history of drug abuse? _____ Do you have a history of sexual abuse? _____
Exercise routine _____ Occupation/Workplace: _____

GYNECOLOGIC HISTORY

Last menstrual period _____ Typical cycle length _____ ***(time between periods)*** Typical menses length _____ ***(time of period)***
Age at first menstruation _____ Age at menopause (if applicable) _____ History of abnormal pap? _____
Last mammogram & result (if applicable) _____ Last pap & result _____

OBSTETRIC HISTORY

Total number of pregnancies _____ _____ Deliveries _____ Living Children _____ Miscarriages _____ Abortion
Date of delivery #1 _____ C-Section _____ Vaginal Delivery _____
Explanations/Complications: _____
Date of delivery #2 _____ C-Section _____ Vaginal Delivery _____
Explanations/Complications: _____
Date of delivery #3 _____ C-Section _____ Vaginal Delivery _____
Explanations/Complications: _____
Date of delivery #4 _____ C-Section _____ Vaginal Delivery _____
Explanations/Complications: _____

REVIEW OF SYSTEMS (Please, check YES for all that you have experienced recently)

General		
Chills	Yes	No
Fever	Yes	No
Weakness	Yes	No
Weight change	Yes	No
Decreased libido	Yes	No
Fatigue	Yes	No

Cardiac		
Chest pain	Yes	No
Swelling of Extremities	Yes	No
Irregular heartbeat	Yes	No
Shortness of breath	Yes	No

Musculoskeletal		
Joint pain	Yes	No
Muscle weakness	Yes	No
Unsteady gait	Yes	No

Endocrine		
Excessive thirst	Yes	No
Cold / Hot Intolerant	Yes	No
Hot flashes	Yes	No
Increased urination	Yes	No
Night Sweats	Yes	No

Skin		
Rash	Yes	No
Unwanted hair growth	Yes	No
Hair loss	Yes	No
Pigment changes	Yes	No

Gastrointestinal		
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No

Neurologic		
Numbness	Yes	No
Headaches	Yes	No
Tingling	Yes	No
Fainting Spells	Yes	No
Memory Loss	Yes	No

Hematologic		
Bleeding easily	Yes	No
Bruising easily	Yes	No

Head, Ear, Eyes, Nose, Throat		
Blurry vision	Yes	No
Sore Throat	Yes	No
Glasses / Contacts	Yes	No
Double vision	Yes	No
Hearing Changes	Yes	No
Sinus Pain	Yes	No

Female Genitourinary		
Blood in urine	Yes	No
Painful urination	Yes	No
Urinary incontinence	Yes	No
Frequent Bladder Infections	Yes	No
Vaginal infections	Yes	No

Psychiatric		
Anxiety	Yes	No
Depression	Yes	No
Mood changes	Yes	No

Respiratory		
Coughing blood	Yes	No
Wheezing	Yes	No

Preferred contact method: ❑ Home Phone _____ ❑ Cell Phone _____ ❑ Work Phone_____
May we leave a voicemail or e-mail? ❑ Yes Voicemail _____ ❑ No Voicemail _____ ❑ Yes e-mail:_____

Does Urology Associates have permission to obtain your prescription history from your insurance company? ❑ Yes ❑ No

****Please, notify your clinician if there is any matter listed that you would like to discuss in further detail.****

Patient Signature: _____ Date: _____
Provider Signature: _____ Date: _____

Female Sexual Function Index

Instructions: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:
Sexual activity can include caressing, foreplay, masturbation and vaginal intercourse.
Sexual intercourse is defined as penile penetration (entry) of the vagina.
Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.
Sexual desire or interest includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.
Sexual arousal includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

Name:_____ MR#:_____ Date:____/____/_____

Total Score ☐

Scoring will be completed by clinician

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?
   - ☐ Almost always or always…..…… (5)
   - ☐ Most times (more than half the time)…… (4)
   - ☐ Sometimes (about half the time)..…… (3)
   - ☐ A few times (less than half the time)..…….. (2)
   - ☐ Almost never or never…….. (1)

   → ☐

2. Over the last 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?
   - ☐ Very high……(5)
   - ☐ High……(4)
   - ☐ Moderate…… (3)
   - ☐ Low**...**…… (2)
   - ☐ Very low or none at all.……..(1)

   → ☐

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?
   - ☐ No sexual activity.……. (0)
   - ☐ Almost always or always**..**…… (5)
   - ☐ Most times (more than half the time)**...**……..(4)
   - ☐ Sometimes (about half the time).……... (3)
   - ☐ A few times (less than half the time)**..**……... (2)
   - ☐ Almost never or never…...……(1)

   → ☐

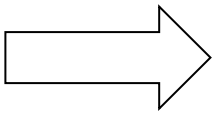
4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?
   - ☐ No sexual activity…….. (0)
   - ☐ Very high…….. (5)
   - ☐ High……... (4)
   - ☐ Moderate…… (3)
   - ☐ Low…….**.....** (2)
   - ☐ Very low or none at all…….. (1)

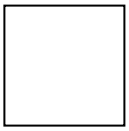
   → ☐

5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?
   - ☐ No sexual activity.…….……(0)
   - ☐ Very high confidence……(5)
   - ☐ High confidence……..(4)
   - ☐ Moderate confidence……...(3)
   - ☐ Low confidence……...(2)
   - ☐ Very low or no confidence……..(1)

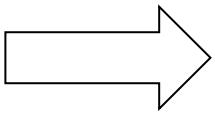
   → ☐

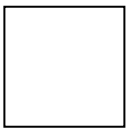
6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?
   - ☐ No sexual activity…… (0)
   - ☐ Almost always or always..…… (5)
   - ☐ Most times (more than half the time)...……..(4)
   - ☐ Sometimes (about half the time)..……... (3)
   - ☐ A few times (less than half the time)..……... (2)
   - ☐ Almost never or never…...……(1)



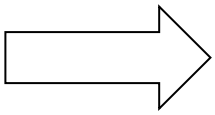


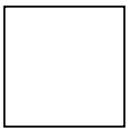
7. Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity or intercourse?
   - ☐ No sexual activity…… (0)
   - ☐ Almost always or always..…… (5)
   - ☐ Most times (more than half the time)...……..(4)
   - ☐ Sometimes (about half the time)..……... (3)
   - ☐ A few times (less than half the time)..……... (2)
   - ☐ Almost never or never…...……(1)



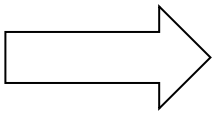


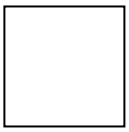
8. Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity or intercourse?
   - ☐ No sexual activity……...(0)
   - ☐ Extremely difficult or impossible**.....**(1)
   - ☐ Very difficult……..(2)
   - ☐ Difficult……...……(3)
   - ☐ Slightly difficult……..(4)
   - ☐ Not difficult…….(5)



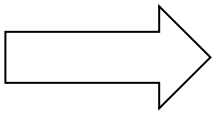


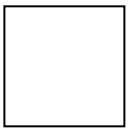
9. Over the past 4 weeks, how often did you **maintain** your lubrication ("wetness") until completion of sexual activity or intercourse?
   - ☐ No sexual activity…… (0)
   - ☐ Almost always or always..…… (5)
   - ☐ Most times (more than half the time)...……..(4)
   - ☐ Sometimes (about half the time)..……... (3)
   - ☐ A few times (less than half the time)..……... (2)
   - ☐ Almost never or never…...……(1)



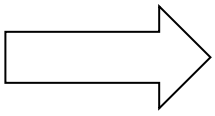


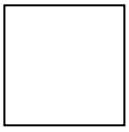
10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?
    - ☐ No sexual activity……...(0)
    - ☐ Extremely difficult or impossible**.....**(1)
    - ☐ Very difficult……..(2)
    - ☐ Difficult……...……(3)
    - ☐ Slightly difficult……..(4)
    - ☐ Not difficult…….(5)



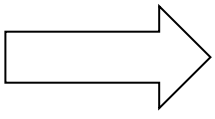


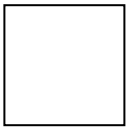
11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?
    - ☐ No sexual activity…… (0)
    - ☐ Almost always or always..…… (5)
    - ☐ Most times (more than half the time)...……..(4)
    - ☐ Sometimes (about half the time)..……... (3)
    - ☐ A few times (less than half the time)..……... (2)
    - ☐ Almost never or never…...……(1)





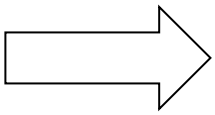
12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?
    - ☐ No sexual activity……...(0)
    - ☐ Extremely difficult or impossible**.....**(1)
    - ☐ Very difficult……..(2)
    - ☐ Difficult……...……(3)
    - ☐ Slightly difficult……..(4)
    - ☐ Not difficult…….(5)

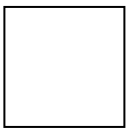




13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

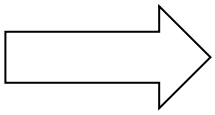
- ☐ No sexual activity……(0)
- ☐ Very satisfied……(5)
- ☐ Moderately satisfied……(4)
- ☐ About equally satisfied and dissatisfied……(3)
- ☐ Moderately dissatisfied……(2)
- ☐ Very dissatisfied……(1)

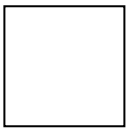




14. Over the past 4 weeks, how **satisfied** have you been with the amount of emotional closeness during sexual activity between you and your partner?

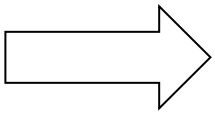
- ☐ No sexual activity……(0)
- ☐ Very satisfied……(5)
- ☐ Moderately satisfied……(4)
- ☐ About equally satisfied and dissatisfied……(3)
- ☐ Moderately dissatisfied……(2)
- ☐ Very dissatisfied……(1)

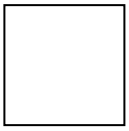




15. Over the past 4 weeks, how **satisfied** have you been with your sexual relationship with your partner?

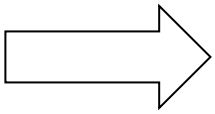
- ☐ Very satisfied……(5)
- ☐ Moderately satisfied……(4)
- ☐ About equally satisfied and dissatisfied……(3)
- ☐ Moderately dissatisfied……(2)
- ☐ Very dissatisfied……(1)

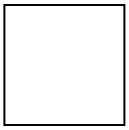




16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

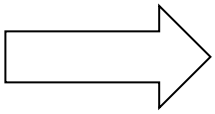
- ☐ Very satisfied……(5)
- ☐ Moderately satisfied……(4)
- ☐ About equally satisfied and dissatisfied……(3)
- ☐ Moderately dissatisfied……(2)
- ☐ Very dissatisfied……(1)

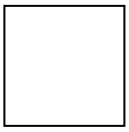




17. Over the past 4 weeks, how **often** did you experience discomfort or pain <u>during</u> vaginal penetration?

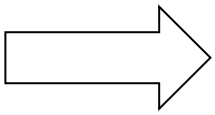
- ☐ Did not attempt intercourse..…… (0)
- ☐ Almost always or always……(1)
- ☐ Most times (more than half the time)……(2)
- ☐ Sometimes (about half the time)……(3)
- ☐ A few times ((less than half the time)……(4)
- ☐ Almost never or never……(5)

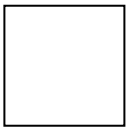




18. Over the past 4 weeks, how **often** did you experience discomfort or pain <u>following</u> vaginal penetration?

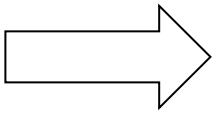
- ☐ Did not attempt intercourse..……(0)
- ☐ Almost always or always……(1)
- ☐ Most times (more than half the time)……(2)
- ☐ Sometimes (about half the time)……(3)
- ☐ A few times ((less than half the time)……(4)
- ☐ Almost never or never……(5)

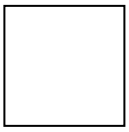




19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

- ☐ Did not attempt intercourse..……(0)
- ☐ Very high……(1)
- ☐ High……(2)
- ☐ Moderate……(3)
- ☐ Low……(4)
- ☐ Very low or none at all……(5)





Thank you for completing this questionnaire!

MRN: _____

Provider: _____

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The Pelvic Pain and Urinary/Frequency (PUF) Patient Symptom Scale

Please circle the answer that best describes how you feel for each question.

	0	*1*	*2*	*3*	*4*	*Symptom Score*	*Bother Score*
1. How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2b. If you get up at night to go to the bathroom does it bother you?	Never	Mildly	Moderate	Severe			
3. Are you currently sexually active? Yes _____ No _____							
4a. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6. Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7a. If you have pain, is it usually…		Mild	Moderate	Severe			
7b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8a. If you have urgency, is it usually…		Mild	Moderate	Severe			
8b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
					Symptom Score *(1, 2a, 4a, 5, 6, 7a, 8a)* =		
					Bother Score *(2b, 4b, 7b, 8b)* =		
					Total Score *(Symptom Score + Bother Score)* =		

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Patient Name:_____ Account#:_____ Date:_____

Which physician are you seeing today? _____

SIGNATURE FORM

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION, AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I am financially responsible to Urology Associates, P.C. for charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. I also agree that, should I fail to assume this financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of the doctor's charges. I authorize Urology Associates, P.C. to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original.

Pf-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Practice Administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge that I have read and understand the Urology Associates P.C. Billing Policies as well as my financial responsibility, and I acknowledge receipt of the Notice of Privacy Practices.

Signature of Patient or Guardian:_____ Date:_____

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

_____ _____
Print name of person/organization Relationship to Patient

_____ _____
Print name of person/organization Relationship to Patient

Please continue only if you have Medicare and/or Medicaid

EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION)

I request that payment of authorized Medicare benefits or other insurance benefits (including Medigap benefits) be made on my behalf to Urology Associates, P.C. for any services furnished me by that provider. This one time signature will be maintained on file as verification for all subsequent services which are provided to you by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or other insurance carriers any information needed to determine these benefits or the benefits payable for related services. I authorize any holder of medical information about me to release to the Medigap Insurer (if applicable) any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Guardian:_____ Date :_____