NEW PATIENT INFORMATION
(PLEASE PRINT)

Please circle one	Ethnic Background:
White	American Indian/Alaskan Native
Hispanic/Latino	Black/African American
Asian	Non-Hispanic/Non-Latino
	Hawaiian /other Pacific Islander

Date _____ M☐ F☐

Patient's Name _____ Date of Birth _____

Street Address _____ Social Security # _____ (optional)

City and State _____ Zip Code _____ Telephone _____

Preferred Language _____

E-mail Address _____ Cell # _____

Employer (Patient or Parent) _____

Employer's Address _____ City and State _____

Employer's Telephone _____ Spouse or Parent's Name _____

Name of Referring Physician _____

Address _____

In case we are unable to reach you, please list a telephone number of a friend or relative we could contact.

Name _____ Relationship _____ Telephone _____

Have you ever seen the doctor before? _____ Reason _____

PLEASE READ: *All charges are due at the time of the service. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.*

INSURANCE INFORMATION

INSURANCE COMPANY	CERTIFICATE #	GROUP #	SUBSCRIBER AND DATE OF BIRTH
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Primary Care Physician _____ Telephone # _____

All professional Services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the PATIENT is responsible for all fees, unless other arrangements have been made IN ADVANCE with our office bookkeeper.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dr. _____ to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date _____ Signature _____

I WILL BE PAYING TODAY BY CASH _____ CHECK _____ CREDIT CARD _____

Please answer the following questions as best you can. This will help me make sure that I have as good a picture of your problem as possible. Thank you.

1. What is the main reason you have come to see the doctor today?_____

   How long have you had this problem?_____

   _____

2. Have you ever had this problem before? If so, what was the diagnosis and how was it treated? _____

   _____

3. Please list any other symptoms that you have. _____

   _____

4. Have any of the following been a problem to you? Please check these in the appropriate space.

	YES	NO	WHEN
a. Blood in your urine	_____	_____	_____
b. Inability to empty your bladder	_____	_____	_____
c. Loss of urine. When does this occur?	_____	_____	_____
d. Increased frequency of urination How often?	_____	_____	_____
e. Awakening at night to urinate	_____	_____	_____
f. Flank pain (kidney)	_____	_____	_____
g. Urgent desire to void	_____	_____	_____
h. Painful urination	_____	_____	_____
i. Decreased force of urinary stream	_____	_____	_____
j. Difficulty starting urinary stream	_____	_____	_____
k. Difficulty having erections	_____		
l. Any lumps or masses	_____		
m. Kidney stones	_____		

5. Please list any allergies you may have. _____

   _____

6. If you are you taking any medications, including vitamins or supplements, please complete the red medication list provided.

7. Are you taking aspirin, Clinoril, Coumadin, or Motrin?

   _____

8. Have you had any operations? If so, please list the operation, surgeon and approximate date._____

_____

_____

9. Do you have any of the following medical problems?

	Yes	No
Diabetes Mellitus	_____	_____
Heart Disease	_____	_____
Have you had a heart attack?	_____	_____
Angina	_____	_____
High Blood Pressure	_____	_____
Bleeding Disorders	_____	_____
Back Problems	_____	_____
Seizures	_____	_____
Fainting	_____	_____
Thyroid Problems	_____	_____
Other Medical Problems	_____	_____

If so, please list them _____

_____

10. Do yo smoke or have you ever been a smoker? Yes _____ No _____

How much? _____

11. How much alcohol do you consume?_____

12. Are you married? Yes _____ No _____ Widowed _____ Divorced _____

13. Do you have any children? Yes _____ No _____ How many? _____

14. Do any diseases run in your family such as heart disease, cancer, diabetes mellitus, kidney disease, etc.?_____

_____

_____

_____

_____

Patient's Name _____ Date _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.
Please explain any Yes answers in space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other _____		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Physician use only: (Comments/Notes)

# Answer	Level of Service
0 - 1	1or 2
2 - 9	3
10+	4 or 5

Physician: _____ Date: ____/____/____

WORCESTER UROLOGICAL ASSOCIATES, INC.
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PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made by either yourself or your health coverage carrier, full payment for office services are due at the time of service.

We have prior arrangements with many health plans to accept an assignment of benefits. You will be required to make the co-payment at the time of your appointment. Should your insurance require a referral and one is not obtained, you will be asked to sign a waiver, making you responsible for payment of services if no referral is received.

CANCELLATION / NO SHOW POLICY

In the event that you need to cancel an appointment, kindly provide 24 hours notice. There is also a **$25.00 fee for a "NO SHOW"**. Please be advised that we cannot bill your insurance company for this fee. It will be your responsibility. Our answering machine is available for any calls during off hours.

If you have insurance coverage with a plan with whom we do not have prior agreement, our charges for your care are due at the time of service. We will give you a receipt which you can send to your insurance company for reimbursement.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____

Signature of Patient or Responsible Party, if a minor — Date

_____

Please Print the Name of the Patient

HIPAA REGULATIONS: Would you like your information shared with anyone?

☐ Yes ☐ No **If yes, please list who:** _____

_____

_____