UROLOGY P.C. & UROLOGY SURGICAL CENTER – Patient Registration

Referring Physician: | **Today's Date**

Primary Care Physician:

PATIENT INFORMATION

Patient's LEGAL Name

Last Name: | First: | M.I. | Birth Date: | Sex: ❑ Male ❑ Female

Nickname: | Former/Maiden name(s):

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated | SSN:

Street Address: | Billing Address (if different):

City | State | Zip Code | **Land Line:** ( ) ❑ Primary | **Cell Phone:** ( ) ❑ Primary

Email address:

Current Work Status: ❑ Full Time ❑ Part Time ❑ Retired ❑ Disabled ❑ Not Employed

Occupation: | Employer Name | Address: | Work Phone & Ext.: ( )

Current College Student: ❑ Full Time ❑ Part Time | Name of School:

PRIMARY CONTACT PERSON (SPOUSE, PARENT, SIGNIFICANT OTHER, ETC.)

Name: | Relationship:

Address: | Employer:

Home Phone: ( ) | Work Phone: ( ) | Cell Phone: ( )

SECONDARY CONTACT PERSON (PARENT, CHILD, NEXT OF KIN, ETC.)

Name: | Relationship:

Address: | Employer:

Home Phone: ( ) | Work Phone: ( ) | Cell Phone: ( )

INSURANCE COVERAGE

Is this patient a Ward of the State? ❑ Yes ❑ No | Case Manager: | Phone:

Is this patient covered by insurance? ❑ Yes ❑ No **If yes, please complete appropriate insurance information below.**

MEDICARE COVERAGE (specify)

Is Medicare Primary? ❑ Yes ❑ No

Medicare #

Railroad Medicare #

Medicare (Hospital Only) #

Medicare Advantage Plan (Unicare, Secure Horizons, etc.)

Plan Name:

Plan # | Group #

MEDICAID (WELFARE) COVERAGE

Is this patient covered by Medicaid? ❑ Yes ❑ No

NE Total Care #

Wellcare #

UHC Community Plan #

SUPPLEMENTAL or OTHER INSURANCE COVERAGE

Insurance Company & Address: | Primary Insurance: ❑ Yes ❑ No

Subscriber's Name | Subscriber's SSN | Subscriber's Date of Birth | Is this a Self/Individual Plan? ❑ Yes ❑ No

Policy # | Group # | Subscriber's Relationship to Patient | Subscriber's Employer

SUPPLEMENTAL or OTHER INSURANCE COVERAGE

Insurance Company & Address: | Primary Insurance: ❑ Yes ❑ No

Subscriber's Name | Subscriber's SSN | Subscriber's Date of Birth | Is this a Self/Individual Plan? ❑ Yes ❑ No

Policy # | Group # | Subscriber's Relationship to Patient | Subscriber's Employer

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What is your preferred pharmacy? _____ Location _____

Race/Ethnicity (circle one): **White** **Hispanic/Latino** **Black/African American** **Asian** **Multi-Racial** **Decline to specify**

Preferred Language (circle one): **English** **Other** _____ ☐ Interpreter Required

Is this medical condition due to an accident of any kind? **YES** **NO**

If yes, was it (choose one): **Work Related** **Auto** **Home** **Other**

Do you have a Living Will or Advanced Directive (please bring a copy with you)? **YES** **NO**

Do you have a Medical Power of Attorney (please provide documentation)? **YES** **NO**

If yes, please indicate name, address & phone: _____

_____

MEDICARE PATIENTS ONLY

1. Are you a Veteran? **YES** **NO**
   If yes, were you referred to us by the VA? **YES** **NO**
   If yes, do you have a written referral for today? **YES** **NO**
2. Do you have a Federal Black Lung Card? **YES** **NO**
3. Do you have a Veterans FEE BASIS ID card? **YES** **NO**
4. Are you covered by a current employer's health insurance plan through you or your spouse's employer? **YES** **NO**
5. Are you entitled to Medicare because of disability or End Stage Renal Disease? **YES** **NO**

→ AUTHORIZATION TO TREAT

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

→ ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. **I understand that I am financially responsible for all allowed charges or co-insurance amounts which are not paid by my insurance company in full within 30 days of the first statement received.**

→ RELEASE OF INFORMATION TO INSURANCE COMPANY

I authorize Urology, PC and/or Urology Surgical Center to release to the Medicare carrier and/or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to Urology, PC or Urology Surgical Center.

→ NEBRASKA STATE LAW REGARDING MINORS - Nebraska state law defines a minor as anyone 18 years of age and younger. These patients are required by this law to have a legal guardian present or if this is not possible, you must make prior arrangements with our office. If prior arrangements are not made, it could result in the appointment needing to be rescheduled.

→ I understand there will be a $25 fee for a no show appointment or returned check (See also Financial Policy) payable only by cash, money order, credit or debit card.

→ I understand the Patient Rights and Responsibilities are listed on Urology, P.C.'s website at www.lincolnurologypc.com and I may request a copy at any time.

I understand that I will be responsible for all charges if the listed insurance information is not correct.

Signature _____ Date _____

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Urology PC Health History

Date:	Name:	DOB:	Sex:	Ht:	Wt:
REASON FOR VISIT:		Preferred Pharmacy Name & Address:			

Please circle YES or NO for each of the following:

Have you had a flu shot? NO YES When? _____
Pneumonia Vaccination? NO YES When?_____

List all Current Medications and dose including over-the-counter, aspirin meds, fish oil, inhalers and vitamins.

List all Allergies to medications and your reactions. ☐ None

	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown

Allergy to Latex? NO YES **Allergy to Iodine?** NO YES

Please List all Previous Surgeries and year performed. ☐ None

Surgery	Year	Surgery	Year

Have you ever had a Colonoscopy? NO YES What year was it performed?_____

Personal Alcohol Use: None How Much:_____ How Often:_____

Personal Caffeine Use: None How Much:_____ How Often:_____

Tobacco Use: (please circle) Never Current Former Age Quit? _____
Type: Cigarettes Cigar Pipe Smokeless How much daily? _____

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Personal Past Medical History: (please circle appropriate answer)

Cancer: NO YES **Type of Cancer:**_____ **Treatment:** Surgery Chemo Radiation

Anemia: NO YES	**Arthritis:** NO YES	**Asthma:** NO YES
COPD/Emphysema/ Chronic Bronchitis: NO YES	**Diabetes:** NO YES If yes, do you take medication for this? NO YES	**Heart Disease (bypass/ stent, surgery):** NO YES
Heart Rhythm Problems: NO YES	**Hepatitis / Liver Disease:** NO YES	**High Blood Pressure:** NO YES
History of Seizure: NO YES	**History of Stroke or TIA:** NO YES	**HIV:** NO YES
Kidney Disease: NO YES	**Multiple Sclerosis:** NO YES	**Muscular Dystrophy:** NO YES
Osteoporosis: NO YES	**Pacemaker/Defibrillator:** NO YES	**Parkinson's:** NO YES
Systemic Lupus: NO YES	**Thyroid Problems:** NO YES	**Urinary or Kidney Stones:** NO YES

Family Cancer History: (Please indicate type and family member) ☐ None

	Cancer	Cancer	Cancer	Cancer
What family member?				
What type?				

☐ I was adopted and have no available health history.

Total Joint Replacement NO YES

If yes, What joint? _____ When was surgery?_____

If yes, have you been told to take antibiotics prior to surgery or dental procedures? NO YES

Anyone in your family have issues with anesthesia: NO YES

If patient is 19 or younger:

Was patient born prematurely? NO YES If yes, how many weeks early?_____
Any developmental delays as a child? NO YES

Form Completed by: _____ Date: _____

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