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

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

Primary Care Physician: Address:

PATIENT INFORMATION

Patient's LEGAL Name

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

Nickname: | Former/Maiden name(s):

Relationship 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 ❑ College Student

Occupation:	Employer Name	Address:	Work Phone & Ext.:

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: ( )

GUARDIANSHIP

Does someone have **court appointed guardianship** for patient? (bring paperwork) ❑ Yes ❑ No | Guardian Name: Phone:

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

INSURANCE COVERAGE

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 (Blue Advantage, Aetna Premier, etc.)

Plan Name:

Plan # | Group #

MEDICAID (WELFARE) COVERAGE

Is this patient covered by Medicaid? ❑ Yes ❑ No

NE Total Care #

Healthy Blue #

UHC Community Plan #

HOME HEALTH CARE

❑ Yes ❑ No

If Yes, list Provider:

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

Member ID	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

Member ID	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

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

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

_____

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

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

MEDICARE PATIENTS ONLY 	1. Has the VA authorized and agreed to pay for your visit today?	**YES** **NO**
	2. Are you receiving benefits from a government research grant?	**YES** **NO**
	3. Do you have a Federal Black Lung 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**
	*If patient marks yes to any of the above 5 questions or accident-related question above, complete full MSPQ.	

→ 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. I understand that not all services are a covered benefit in all insurance plans and that my insurance coverage is an agreement between me and my insurance company. Should I elect to proceed with a non-covered benefit service, I understand I am financially responsible. We offer monthly auto debit payment plans based on account balance and low interest bank loans upon request. We do use outside agencies as a means of collections should we deem it necessary.

→ ADVANCE DIRECTIVES

You have the right to have an advance directive, such as a living will or health care proxy. However, due to CMS regulations, our clinic and surgical center will suspend Advance Directives at our facilities. In the event of an emergency, we will attempt to stabilize you and transfer you to an acute care facility for evaluation and treatment as appropriate.

→ 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 hereby consent to receive calls, texts and emails from Urology, P.C. or any business associates Urology, P.C. has contracted with at the phone number(s) and email addresses provided or associated with my account. I understand that methods of contact may include pre-recorded or artificial message and/or use of an automated dialing system.

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

Signature_____ Date _____

(OVER →)

Urology PC Health History

Date:	Name:	DOB:	Ht:	Wt:

Current Gender:	Gender Identity:	Preferred Pronoun:

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**

Allergy	Reaction	Allergy	Reaction
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown
	☐ Unknown		☐ Unknown

Allergy to Latex? NO YES

Have you had a reaction to or do you have an allergy to Iodine? NO YES

Have you ever had an antibiotic resistant infection

such as MRSA or VRE? NO YES if Yes circle, ACTIVE HISTORY OF

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? _____

(OVER →)

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 or Partial 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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