

PATIENT REGISTRATION INFORMATION						
Name <small>Last First M.I.</small>			Social Security #:			
Address <small>Street Apt# City/State Zip Code</small>						
Telephone () () () ()		<small>Home Work Cell Home Fax</small>				
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date: / /	Age:	Minor: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race: <input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other:						
Marital Status:		<input type="checkbox"/> Divorced	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> single <input type="checkbox"/> Widowed	
Email address:			Religion:			
Occupation:		Employer:		Employer Telephone: ()		
Employer Address: <small>Street City/State Zip Code</small>						
Allergies: <input type="checkbox"/> None Known <input type="checkbox"/> Yes			Diabetes: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Do you have a Living Will or Advanced Directives? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please bring with you)						
Can we leave messages containing medical information on your home answering machine/voicemail: <input type="checkbox"/> No <input type="checkbox"/> Yes						
Please identify the person/relative/kin authorized to receive your personal medical information below:						
Name:		Relationship:		Telephone: ()		
PRIMARY INSURANCE INFORMATION						
Primary Insurance Company			Authorization #:			
Subscribers Name <small>Last First M.I.</small>			Relationship to Patient:			
Subscribers Social Security #: - -		Subscribers Birth Date: / /		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Policy/ID #:		Group #:		Copoly Amount \$:		
Employer:						
SECONDARY INDURANCE INFORMATION						
Primary Insurance Company			Authorization #:			
Subscribers Name <small>Last First M.I.</small>			Relationship to Patient:			
Subscribers Social Security #: - -		Subscribers Birth Date: / /		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Policy/ID #:		Group #:		Copoly Amount \$:		
Employer:						
RESPONSIBLE PARTY <input type="checkbox"/> Same as Patient (Do not complete remaining section)						
Name <small>Last First M.I.</small>			Relationship to Patient:			
Address <small>Street Apt# City/State Zip Code</small>						
Social Security #: - -		Birth Date: / /				
Employer:			Employer Telephone ()			

NAME: _____ DOB: _____ DATE: _____

Reason of visit: _____

NEW PATIENT MEDICAL HISTORY

Please **CHECK** illnesses or conditions which you have or had:

- High Blood Pressure Stroke/TIA Hypothyroidism Cancer: _____
- Diabetes Arthritis/Gout Asthma Depression
- High Cholesterol Kidney Disease Hepatitis Anxiety
- Heart Disease Sleep Apnea High Cholesterol Other: _____

Surgeries- Please list ANY surgical Procedures

Procedure	Year	Procedure	Year

Medications- Please list ALL CURRENT medicines

Medications	How Much/ how Often	Medications	How Much/ How often

Allergies- Please list all MEDICATION allergies

SOCIAL HISTORY

Smoking	Yes	No	Never	Smoke(d) _____ packs/day for _____ yrs OR quit for _____ yrs
Alcohol	Yes	No	Never	Have _____ drinks/day OR I drink socially (less than 3 drink/wk)

FAMILY HISTORY

	Living	Present age or age at death	Significant Health problems
Father	Yes No		
Mother	Yes No		
Sibling(s)	Yes No		
Spouse/Partner	Yes No		
Children	Yes No		

Review of Systems: do you **CURRENTLY** have any problems related to the following systems?

- Significant weight change
- Eye disease, injury, impaired sight
- Trouble with nose, sinuses, mouth, throat
- Bleeding gums
- Trouble swallowing
- Chest pain or tightness in the chest
- Coughing up blood
- Night sweats
- Palpitations
- Swelling of hands or feet
- Weakness in arm or leg
- Varicose veins
- Stomach trouble or ulcer
- Constipation or diarrhea
- Hemorrhoids or rectal bleeding
- Fainting spells
- Loss of consciousness
- Spells of dizziness
- Convulsions
- Pain radiating down arm
- Shortness of breath
- Burning pain on urinating
- Loss of bladder control
- Blood in urine
- Frequent urination
- Trouble with erections
- Painful intercourse
- Breast lumps
- Frequent or severe headaches
- Paralysis
- Enlarged glands
- Enlarged thyroid or goiter
- Pain in joints or gout
- Skin irritation or rashes
- Depression or anxiety
- Hallucinations



Name: _____ DOB: _____ Date: _____

PAST UROLOGIC HISTORY

Urinary Tract Infection Yes No
Type: Bladder/Cystitis Kidney
Frequency: Less than once a year Several times a year
Symptoms: Involved high fever and pain
Treatment: Previously evaluates By Whom and where? _____

History of Venereal disease Yes No Date: _____ Treatment: _____

History of prostatitis Yes No Date: _____ Treatment: _____

History of urinary stones Yes No
Type: Bladder Kidney Date: _____ Treatment: _____

Urinary Tract cancer: Yes No
Type: Adrenal Kidney Bladder Prostate Testis Penile
Treatment: Dates & Procedures _____

Sexual Dysfunction Yes No
 Decreased desire for sex Decreased frequency of erections Trouble maintaining erections
 Premature ejaculation Painful erection Painful intercourse

Previous urologic procedures Yes No
 Surgery for kidney stones Surgery for enlarged prostate Surgery for urinary cancer
 Surgery for urinary tract infections Surgery for urinary reflux Other: _____

Prostate cancer Screening (PSA) Yes No
Results: Date PSA value

Females Only:
Date of last Pap: _____ Normal Abnormal
Last menstrual cycle: _____
Date of last mammogram: _____
Periods are: Regular Irregular Pain Cramps
Number of pregnancies: _____
Number of miscarriages: _____
Birth control method: _____



WASHINGTON UROLOGY

Patient Financial Responsibility for Physician Services

Washington Urology at Virginia Hospital Center is a department within VHC Physician Associates.

We are committed to providing you with the best possible care and will help you receive your maximum allowable insurance benefits. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

With your signature below, you hereby acknowledge and authorize the following:

1. Consent for treatment, administration of medications, and performance of any procedures that may be considered necessary or advisable.
2. Assignment of insurance benefits of VHC Physician Associates. This is to include private insurance, Medicare, and Worker's Compensation benefits. In doing so, I authorize release of any information necessary to process the claim.
3. Financial responsibility. The undersigned agrees, in consideration of services rendered by VHC Physician Associates, to be responsible for payment in full, including any collection or attorney's fees related to non-payment when payment is due. All payments are due upon receipt of the bill.

VHC Physician Associates will submit your claim to your insurance plan. It is the responsibility of the patient to provide the practice with updated demographic and insurance information for accurate billing. Due to current regulations, all co-payments, deductibles, or non-covered services must be paid at the time of service. Additional fees that are not typically covered by insurance plans will be charges for services, such as a copying medical records and completion of insurance forms or plans of care. For patients who do not have health insurance, payment in full is required at the time of the visit for all services. A \$30.00 fee will be charged for appointments cancelled without 24-hour notice. A \$25.00 fee will be charged for all returned checks. An additional monthly fee of 5% will be charged on all past-due accounts.

With my signature, I also acknowledge reading and being given a copy of the Notice of Privacy practices.

Patient signature: _____ Date: _____
Printed Name: _____
Parent/Guardian: _____ Date: _____
Relationship to Patient: _____
Witness if signature: _____ Date: _____

How did you hear about Washington Urology?

(Please check all that apply)

- HealthReach – Virginia Hospital Center’s Magazine

- Virginia Hospital Center Web Site

- Washington Urology Web Site
Keywords/Search Terms Used: _____

- Physician Referral – Dr. _____
(Name)

- Insurance Provider _____

- Friend/Family Recommendation

- Other _____

Telephone Number _____

What is your zip code? _____

Date _____

Thank you for entrusting Washington Urology with your medical care.