



# SKYLINE UROLOGY

# Patient Registration Form

(Please Print & Complete in Full)

### PATIENT INFORMATION

Social Security Number		Email Address	
First Name	MI	Last Name	
Address			
City	State	Zip	

MRN: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex:  Male  Female

Marital Status:  Single  Married  Widowed  Divorced  Separated

Home Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Race:  African American  Asian  Caucasian  Hispanic  Native American  Other

Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

If Patient is a child, lives with:  Both Parents  Mother  Father  Other: \_\_\_\_\_

Name of Person (With Whom Child Lives With): \_\_\_\_\_

### RESPONSIBLE PARTY IF OTHER THAN PATIENT

Social Security #: \_\_\_\_\_ Responsible Party Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female Relationship: \_\_\_\_\_

### REFERRED BY:

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

PCP Physician: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

### IN CASE OF EMERGENCY

Relative/Friend: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Work Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_

### PHARMACY INFORMATION

Pharmacy (Name, Street Name & Phone Number, if known): \_\_\_\_\_

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but not limited to co-pays, deductibles, self pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize Skyline Urology and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees through the services of an attorney or collection agency, I understand this will increase my balance approximately 30%.

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



**SIGNATURE FORM**

**FINANCIAL RESPONSIBILITY AND  
RELEASE OF INFORMATION**

**SKYLINE  
UROLOGY**

Patient Name: \_\_\_\_\_

MRN#: \_\_\_\_\_

Date: \_\_\_\_\_

I understand that I am financially responsible to **Skyline Urology** 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 that 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 **Skyline Urology** 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Guardian

**EXTENDED PAYMENT REQUEST (One Time Authorization)  
(Medicare and Medicaid Patients ONLY)**

I request that payment of authorized Medicare benefits or other insurance benefits be made on my behalf to **Skyline Urology** 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 for related services.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Guardian

**MEDIGAP AUTHORIZATION  
(Medicare Patients only)**

I request that payment of authorized Medigap benefits be made on my behalf to **Skyline Urology** for any services furnished me by that provider. I authorize any holder of medical information about me to

Release to \_\_\_\_\_ any information needed to determine these benefits  
(Name of Medigap Insurer)

Or the benefits payable for related services.

Medicare Number: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Guardian



# SKYLINE UROLOGY

MRN: \_\_\_\_\_

Patient's Name	
Date	
Age	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Occupation (or former occupation)	

## Chief Complaint:

What is the main reason for your visit today? (Please describe in detail)

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## History of Present Illness:

Location of problem: Abdomen            Back            Genitals Other: _____	How long does the problem last? 30 minutes            1 day            Always there Other: _____
On a scale of 1-10, with 10 being the most severe, circle the number that best describes your problem 1   2   3   4   5   6   7   8   9   10	Is there anything else occurring at the same time? Yes    No    If Yes, explain _____ Nausea            Rash            Headache Other: _____
When did you first notice the problem? 2 days ago            1 week ago            1 month ago Other: _____	Is the problem constant or variable? Dull, then sharp            Sharp, then leaves Always there Other: _____
Does anything help or make the problem worse? Yes            No Moving around            Standing            Eating	Does the problem interfere with your normal function? Yes            No If yes, explain: _____ _____

Physician use (comments and notes)



**SKYLINE  
UROLOGY**

Patient's Name	Date
Who referred you to this office?	Medical Doctor/PCP
Why are you seeing the physician today?	
When did your problem start?	Pharmacy (Name & Number)

MRN: \_\_\_\_\_

**My Main Problems are:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Blood in Urine       | <input type="checkbox"/> High PSA             | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> Kidney Stones     | <input type="checkbox"/> Prostate Infection   | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Bladder Cancer    |
| <input type="checkbox"/> Prostate Cancer   | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Overactive Bladder   | <input type="checkbox"/> Infertility       |
| <input type="checkbox"/> Lump in Testicle  | <input type="checkbox"/> Other: _____         |   |  |

**Allergies:**

- |                                       |                              |                                |                                |  |
|---------------------------------------|------------------------------|--------------------------------|--------------------------------|--|
| <input type="checkbox"/> None         | <input type="checkbox"/> PCN | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Cipro | <input type="checkbox"/> Iodine/Contrast |
| <input type="checkbox"/> Other: _____ |                              |                                |                                |  |

**Medications (Please list all current medications):**

- Surgical History:**
- |   |   |                                      |  |
|---|---|--------------------------------------|--|
| <input type="checkbox"/> Appendectomy     | <input type="checkbox"/> Back/Hip/Knee        | <input type="checkbox"/> Cystoscopy  | <input type="checkbox"/> Gallbladder     |
| <input type="checkbox"/> Heart Bypass     | <input type="checkbox"/> Kidney Stone Surgery | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Prostate Surgery | <input type="checkbox"/> Prostate Seed        | <input type="checkbox"/> No Changes  |  |
| <input type="checkbox"/> Other: _____     |   |                                      |  |

- Medical History:**
- |                                    |                                       |                                       |                                       |
|------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Emphysema    | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia       | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Parkinson's  |
| <input type="checkbox"/> Strokes   | <input type="checkbox"/> Other: _____ |                                       |                                       |
- Cancer:**  Prostate  Kidney  Testis  No Changes

- Family History:**
- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Kidney Cancer | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Heart Disease |
|--|--|--|--|

**Social History:**

- Marital Status:  Single  Married  Divorced  Widowed
- Smoke:  No  Yes **Occupation:** \_\_\_\_\_  Retired

**My Symptom(s) are:**

- |                           |  |   |  |
|---------------------------|--|---|--|
| General/Constitutional    | <input type="checkbox"/> Fever               | <input type="checkbox"/> Weight Loss        | <input type="checkbox"/> Chills              |
| Eyes                      | <input type="checkbox"/> Blurry Vision       | <input type="checkbox"/> Double Vision      | <input type="checkbox"/> Cataracts           |
| Ears, Nose, Mouth, Throat | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> Nasal Stuffiness   | <input type="checkbox"/> Sore Throat         |
| Cardiovascular            | <input type="checkbox"/> Chest Pains         | <input type="checkbox"/> Swollen Ankles     | <input type="checkbox"/> Irregular Heartbeat |
| Respiratory               | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing           | <input type="checkbox"/> Chronic Cough       |
| Gastrointestinal          | <input type="checkbox"/> Abdominal Pain      | <input type="checkbox"/> Nausea/Vomiting    | <input type="checkbox"/> Change in Bowels    |
| Genitourinary             | <input type="checkbox"/> Incontinence        | <input type="checkbox"/> Painful Urination  | <input type="checkbox"/> Blood in Urine      |
| Musculoskeletal           | <input type="checkbox"/> Chronic Back Pain   | <input type="checkbox"/> Chronic Neck Pain  | <input type="checkbox"/> Sore Muscles        |
| Integumentary/Skin        | <input type="checkbox"/> Rash                | <input type="checkbox"/> Persistent Itching | <input type="checkbox"/> Skin Cancer History |
| Neurologic                | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Tingling           | <input type="checkbox"/> Dizziness           |
| Hematologic/Lymphatic     | <input type="checkbox"/> Swollen Glands      | <input type="checkbox"/> Abnormal Bleeding  | <input type="checkbox"/> Transfusion History |

**Urinary Symptom(s) are:**

- |  |   |   |                                      |                                    |
|--|---|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Incomplete Emptying | <input type="checkbox"/> Frequency          | <input type="checkbox"/> Intermittency              | <input type="checkbox"/> Weak Stream | <input type="checkbox"/> Straining |
| <input type="checkbox"/> Testicle Pain       | <input type="checkbox"/> Pain in Side R / L | <input type="checkbox"/> Urinating at Night # _____ |                                      |                                    |



# SKYLINE UROLOGY

## 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 your office's 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 receipt of the Notice of Privacy Practices.**

\_\_\_\_\_  
PRINT PATIENT'S NAME

\_\_\_\_\_  
PATIENT MRN NUMBER

\_\_\_\_\_  
Patient or Legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name if signed on behalf of the patient

\_\_\_\_\_  
Relationship to Patient

**(Notation, if any, by staff)**

### 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