Patient Registration Form

(Please Print & Complete in Full)

MRN: ____________________

Date: ____________________

PATIENT INFORMATION

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

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:** _________________

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SIGNATURE FORM

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

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

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MRN: ____________________

Patient's Name	
Date	
Age	☐ Married ☐ Single ☐ Widowed ☐ Divorced
Occupation (or former occupation)	

Chief Complaint:

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

____

____

____

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)	

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MRN: ____________________

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)

My Main Problems are:

☐ Blood in Urine ☐ Bladder Cancer ☐ Bladder Infection ☐ Bladder Pain
☐ Kidney Stones ☐ Interstitial Cystitis ☐ Leak Urine ☐ Overactive Bladder
☐ Dropped Bladder ☐ Other: ______________________________

Allergies:

☐ None ☐ PCN ☐ Sulfa ☒ Cipro ☐ Iodine/Contrast
☐ Other: ______________________________

Medications: ☐ None ☐ Aspirin ☐ Lortab ☐ Percocet ☐ Plavix ☐ Nitroglycerin
☐ Detrol ☐ Detrol LA ☐ Vesicare ☐ Allopurinol ☐ Coumadin
☐ Antibiotic: ____________________ ☐ Other: ____________________

Surgical History: ☐ Appendectomy ☐ Back/Hip/Knee ☐ Bladder Tack ☐ C-Section # ______
☐ Cystoscopy ☐ Gallbladder ☐ Heart Bypass ☐ Hysterectomy ☐ Kidney Stone Surgery
☐ Lithotripsy ☐ Sling (TVT) ☐ Vaginal Deliveries # ______ ☐ Other: ______________ ☐
No Changes

Medical History: ☐ Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur
☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Last Period: _____ ☐ Menopause
☐ Parkinson's ☐ Pregnant ☐ Strokes ☐ Cancer: ____________________
☐ Other: ____________________ ☐ **No Changes**

Family History: ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Smoke: ☐ No ☐ Yes **Occupation:** ____________________ ☐ Retired

My Symptom(s) are:

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

Urinary Symptom(s) are:

☐ Frequency ☐ Urgency ☐ Leakage ☐ Straining ☐ Abdominal Pain
☐ Bladder Pain ☐ Pain in Side R / L ☐ Not Emptying Bladder ☐ Urinating at Night # __________

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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