



UroCare

*Practice Limited to Urology
and Urological Surgery*

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New Patient Information: Please print and FILL-OUT COMPLETELY. (USE BLACK INK ONLY)

Legal Name: _____ **Date of Birth** _____

Height _____ in. **Weight** _____ lbs. **Sex:** M or F **Social Security#** _____

Address: _____ **City** _____ **State&Zip** _____

Home Phone: _____ **Work or Mobile Phone:** _____

Pharmacy: _____ **Address:** _____ **Fax:** _____

May we call you at work? Yes___ No___

May we leave detailed messages on your voicemail? Yes___ No___

May we discuss your medical information with family members? Yes___ No___

If yes, Name _____ Phone _____

Primary Physician _____ **Phone** _____

Fax _____

Next of Kin or Emergency Contact Information

Name _____ **Relationship** _____

Home Phone _____ **Work Phone** _____

- I have read all of the information on the UroCare Billing Policy that was provided to me and acknowledge my financial responsibilities.
- I understand and agree, regardless of my insurance status, I am ultimately responsible for my co-pay, deductible, and any non-covered charges.
- I was provided with Notice of Privacy Practice, and aware that Urocare send appointment reminder cards.

I certify that I have read all of the information provided to me by Urocare, and that to the best of my knowledge, that all information that I have provided are correct and true. I will notify this office in case of any changes to my health or any of the information I have provided. I hereby authorize the release of all pertinent medical information to insurance carriers for the purpose of payment.

Signature: _____ **Date:** _____



MEDICAL HISTORY

FORM 2A

Patient Name: _____

Date: _____

PLEASE FILL OUT ALL SECTIONS

We need to know your past medical history to best understand how we can help you.

What is the reason for your visit?

Prior and current illnesses or serious injuries None

Prior surgeries or hospitalizations None

Current Medications – Doses and schedule None

Allergies and reactions to drugs, foods, or other None

FAMILY MEDICAL HISTORY

Check all that apply: None

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Chronic Obstructive
Pulmonary Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Congestive Heart
Failure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypercholesterolemia
(Elevated Cholesterol) | <input type="checkbox"/> Prostate Cancer |



PATIENT NAME: _____ **DATE:** _____

Other Family History:

SOCIAL HISTORY

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Number of Children: _____

Living Situation: ___ Living At Home ___ Nursing Home

Employment: ___ Employed ___ Retired Occupation _____

Education: ___ High School ___ College ___ Advanced Degree ___ Other

TOBACCO USE: ___ Non-Smoker ___ Former Smoker ___ Smoke-Less Tobacco (Chew Tobacco)

Type: ___ Cigarettes ___ Cigars ___ Pipe

_____ Packs (uses) per ___ Day ___ Week ___ Month

ALCOHOL USE: ___ Drinker ___ Former Drinker ___ Non-Drinker

Type: ___ Beer ___ Wine ___ Hard Liquor

_____ Drinks per ___ Day ___ Week ___ Month

Years of Use _____ **Quit Date** _____

DRUG USE: ___ User ___ Former User ___ Non-User

Type: _____

_____ Ounces per ___ Day ___ Week ___ Month

Years of Use _____ **Quit Date** _____



MEDICAL HISTORY

FORM 2B

Patient Name _____

Date _____

Please circle "Yes" or "No" to all questions and describe your current medical condition.

Constitutional Symptoms

Fever.....NO YES
Weakness.....NO YES
Weight Loss.....NO YES

Integumentary (breast/skin)

Skin Infections.....NO YES
Rash.....NO YES

Eyes

Loss of vision
___Right ___Left.....NO YES
Blurry Vision
___Right ___Left.....NO YES

Ears, Nose, Mouth, Throat

Head:
Headaches.....NO YES

Ears:
Dizziness.....NO YES
Congestion.....NO YES
Ringing in the ears.....NO YES

Nose:
Nosebleeds.....NO YES

Mouth/Throat:
Difficulty swallowing.....NO YES
Sore throat.....NO YES

Cardiovascular

Swelling of feet, ankles or hands.....NO YES
Shortness of breath.....NO YES
Racing heart beats.....NO YES
Chest pain at rest.....NO YES
Chest pain at exercise.....NO YES

Respiratory

Chronic or frequent cough.....NO YES
Wheezing.....NO YES

Gastrointestinal

Heartburn.....NO YES
Abdominal pain.....NO YES
Diarrhea.....NO YES
Vomiting.....NO YES
Nausea.....NO YES
Constipation.....NO YES

Genitourinary

Frequent Urination.....NO YES
Urgent need to urinate.....NO YES
Pain with urination.....NO YES
Nighttime urination.....NO YES
Number of times per night.....
Difficulty starting urinary stream.....NO YES
Leakage or Dribbling.....NO YES
Reduced flow.....NO YES
Blood in urine.....NO YES
Straining to urinate.....NO YES
Sexual difficulty.....NO YES
Female – irregular periods.....NO YES

Musculoskeletal

Joint pain.....NO YES
Muscle weakness.....NO YES
Leg cramps.....NO YES

Neurological

Confusion.....NO YES
Headache.....NO YES
Fainting.....NO YES
Seizures or convulsion.....NO YES
Memory Loss/Dementia.....NO YES

Psychiatric

Anxiety.....NO YES
Insomnia.....NO YES

Endocrine

Excessive thirst.....NO YES
Low-level of activity/tired.....NO YES

Hematologic

Excessive bleeding with dental work.....NO YES
Bruising.....NO YES

Allergic/Immunologic

Frequent Skin rashes.....NO YES
Frequent infections.....NO YES

Patient Signature _____

Physician Signature _____



UROCARE BILLING POLICY

PATIENT FINANCIAL RESPONSIBILITY

1. If insurance card is unavailable, payment is required in full at time of service.
2. Payment can be made with cash, check, Visa, MasterCard, and debit cards.
3. ***The bill for services rendered is your responsibility, the patient.*** We participate in many managed care plans, will file and make attempt to collect our allowable fees, however, if they do not pay in a timely fashion ***it is ultimately your responsibility*** and we will expect payment from you.
4. If you are covered by an insurance plan, you must provide:
 - a. Co-payment at time of service.
 - b. Valid insurance card and verification at or before date of service.
 - c. If you have HMO insurance, and a referral is required, it is your responsibility to bring it at time of service.

BILLING POLICY

1. **There will be a \$25.00 service charge (plus bank charges) for any returned check.**
2. **You will be charged \$50.00 if you do not show up or cancel your appointment within 24 hours of a scheduled office visit or follow up.**
3. **You will be charged \$75.00 if you do not show up or cancel your appointment within 24 hours of a scheduled procedure.**

For patients who are underage, non-emergent treatment will be denied unless the adult accompanying the minor accepts responsibility.

UROCARE NOTICE OF PRIVACY PRACTICES

We are to inform you that Urocare send out appointment reminders to all patients in a form of a post card.

We are required by law to provide you with a notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information that is described in the privacy notice.