PATIENT REGISTRATION

PLEASE PRINT

PATIENT: _____
Last Name First Name Middle Initial

ADDRESS: _____

_____
City State Zip

HOME PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

SPOUSE/PARTNERS'S NAME: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ PARTNERED ☐ SEPARATED ☐ WIDOWED

RACE: ☐ AMERICAN INIDIAN ☐ ASIAN ☐ BLACK ☐ NATIVE HAWAIIAN ☐ WHITE ☐ OTHER

ETHNICITY: ☐ NON HISPANIC ☐ HISPANIC

PATIENT'S BIRTHDATE: _____ SPOUSE'S NAME: _____

PATIENT'S SOC. SEC.#: _____ SPOUSE'S BIRTH DATE: _____

PATIENT'S EMPLOYER: _____ SPOUSE'S SOC. SEC.# _____

PATIENT'S OCCUPATION: _____ SPOUSE'S EMPLOYER: _____

WORK PHONE: _____ WORK PHONE: _____

PERSON RESPONSIBLE FOR BILL

NAME: _____ EMPLOYER: _____

MAILING ADDRESS: _____ OCCUPATION: _____

CITY, STATE, ZIP: _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S NAME: _____

PATIENT'S RELATIONSHIP: _____ PATIENT'S RELATIONSHIP: _____

TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐OTHER TO SUBSCRIBER: ☐ SELF ☐SPOUSE ☐ OTHER

SUBCRIBER'S SOC. SEC.# _____ SUBCRIBER'S SOC. SEC.# _____

SUBSCRIBER'S BIRTH DATE: _____ SUBSCRIBER'S BIRTH DATE: _____

SUBSCRIBER'S EMPLOYER: _____ SUBSCRIBER'S EMPLOYER: _____

ID#: _____ GROUP#: _____ ID#: _____ GROUP#: _____

OTHER INFORMATION

IN CASE OF EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED (NOT LIVING AT SAME ADDRESS).

NAME: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ WORK PHONE: _____

SIGNED: _____ DATE: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HIPAA has specific guidelines to protect patient's privacy specifically restricting health information. In an effort to provide efficient, patient friendly care please complete the following authorizations outlining your communication preferences.

VOICEMAIL AUTHORIZATION

I authorize Urology of Greater Atlanta, LLC, it's physicians and employees to leave detailed messages on the phone number(s) listed below. I understand that once a voicemail message exists, it is no longer covered under HIPAA and therefore is **not** protected from unauthorized access. I understand it is my responsibility to provide updated contact information if my contact numbers change in the future.

Home Voicemail: ☐ Yes ☐ No Number: _____

Work Voicemail: ☐ Yes ☐ No Number: _____

Cellular Voicemail: ☐ Yes ☐ No Number: _____

_____ _____
Patient or Guardian Name Relationship if other than self

_____ _____ _____
Signature Date Birthdate

REQUEST FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize Urology of Greater Atlanta, LLC, it's physicians and employees to disclose my health information to the following person(s). Further, I acknowledge the following regarding the Notice of Privacy Practices.

☐ I received a copy of Urology of Greater Atlanta, LLC's Notice of Privacy Practices

☐ I declined the offered copy of Urology of Greater Atlanta, LLC's Notice of Privacy Practices. A copy of the notice is available at www.ugatl.com.

Name: _____ Number: _____ Relationship: _____

Name: _____ Number: _____ Relationship: _____

_____ _____
Patient or Guardian Name Relationship if other than self

_____ _____ _____
Signature Date Birthdate

MEDICATION HISTORY CONSENT

An accurate medication history will allow our physicians to treat you properly and avoid potentially dangerous drug interactions. Our practice electronically requests access to your medication history which lists the prescription medicines that we or other physicians have prescribed to you. This list is collected from a variety of sources including your pharmacy and health insurer. I hereby authorize Urology of Greater Atlanta, LLC to electronically request my medication history. I understand that this authorization can be revoked at any time by submitting a written request to the practice. This authorization to release detailed health information will expire one (1) year from the effective date listed above.

_____ _____
Patient or Guardian Name Relationship if other than self

_____ _____ _____
Signature Date Birthdate

ELECTRONIC COMMUNICATION CONSENT

I understand that Urology of Greater Atlanta, LLC utilizes electronic communication processes to deliver information to its patients in a timely and cost effective manner. Cellular telephone calls, text messages, emails and the online patient portal are utilized to convey information such as appointment reminders, preventive care reminders, patient recalls, patient billing information and statements, practice announcements and practice newsletters.

Information is not sold or distributed outside of our practice. Patients can opt out of the electronic text communication and/or email communication at any time. ***Patients opting out of electronic communications will not receive appointment reminders and therefore will be subject to a $25 missed appointment fee.***

I understand it is my responsibility to provide updated contact information if my email address or cellular telephone number changes in the future.

I opt to receive cellular telephone text messages. ☐ Yes ☐ No

Cellular Number:_____

I opt to receive e-mail communications. ☐ Yes ☐ No

E-Mail Address:_____

_____ _____
Patient or Guardian Name Relationship if other than self

_____ _____ _____
Signature Date Birthdate

PRACTICE POLICIES

If insured, Urology of Greater Atlanta, LLC will submit insurance claims on my behalf. I understand I'm ultimately responsible for payment of all services rendered to me including uninsured services, non-covered services, copayments, co-insurance and deductibles. I understand it is my responsibility to provide any referral required by my insurance carrier to the office prior to my visit. I understand that failure to do so may result in denial of my insurance claim. I understand that patients with past due balances and/or collection balances may be restricted from scheduling non-emergent services.

I understand it is my responsibility to update my address, telephone number, email address and insurance information at each visit.

I understand there is a $25 fee for FMLA forms, disability forms, medication prior authorizations and for copies of medical records not sent to another treating physician.

I understand that should it be necessary to place my account with an outside collection agency a collection agency fee of twenty-eight (28%) of the outstanding balance will be added to my account. I understand that I will be assessed a $30 fee for returned checks and credit/debit card chargebacks.

_____ _____
Patient Name Patient Birthdate

_____ _____
Patient (Guardian) Signature Date

UROLOGY OF GREATER ATLANTA, LLC

CONSENT FOR ROUTINE PROCEDURES AND TREATMENT

Important: Do not sign this form without reading and understanding its contents

During the course of my care and treatment, I understand that various types of tests, routine screening or diagnostic procedures ("procedures") may be necessary. While routinely performed without incident, there may be material risks associated with each of these procedures. I understand that it is not possible to list every risk for every procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the procedures.

The procedures may include, but are not limited to the following:

1) **Physical tests, assessments and treatments** including vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these procedures include, but are not limited to allergic reaction, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition or death. Apart from using modified procedures, no practical alternative exists.

2) **Needle sticks**, such as shots and injections have material risks that may include, but are not limited to, nerve damage, infection infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis, partial paralysis or death. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

3) **Drawing blood and bodily fluid or tissue samples** that are done for laboratory testing and analysis. The material risks associated with these procedures include, but are not limited to paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

4) **Administration of medications** whether orally, rectally, topically or through the eye, ear, or nose. The material risks associated with these types of procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

5) **Insertion of internal tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, and enemas. The material risks associated with these types of procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

By signing this form:

- I acknowledge that I have been informed in general terms of the nature and purpose of the procedures, the material risks of the procedures, and practical alternatives to the procedures. If I have any questions or concerns regarding these procedures, I will ask my physician to provide me with additional information. I also understand my physician may ask me to sign additional informed consent documents.

- I understand that the healthcare professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the procedures. Therefore, I agree to provide accurate and complete information about my medical history.

- I consent to Urology of Greater Atlanta, LLC's healthcare professionals performing procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained. I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES** have been made to me concerning the outcome and/or result of any procedures.

Signature of Patient or Authorized Representative	**Date**
Reason Patient is Unable to Sign (if applicable)	**Relationship to Patient**

Urology of Greater Atlanta, LLC

Payment Options

1. Enroll in the e-billing process by placing a payment method on file and authorizing a future charge up to a maximum of $250 per visit for amounts owed by me as determined by my insurance company. Amounts owed by me may include (i) copayments, (ii) coinsurance, (iii) deductibles, (iv) non-covered or out-of-network services or (v) fees (if applicable) charged by the practice for forms, medical records, appointment cancellations, NSF fees, credit card charge backs, etc.

   ☐ **I elect to enroll in the e-billing system.**

2. Pay your estimated co-insurance and deductible at the time of service. We have an office visit estimation tool that will allow us to estimate your co-insurance and deductible.

   ☐ **I elect to pay my estimated patient responsibility prior to my visit today.**

I have had the opportunity to review the financial policy of Urology of Greater Atlanta, LLC. I confirm that I have received a copy of the policy for my records or that I have declined a copy. I understand that I am ultimately responsible for payment of services rendered to me and/or my dependents. I have indicated my preferred method to handle patient responsibility above.

_____ _____

Patient Name Patient Birthdate

_____ _____

Patient (Guardian) Signature Date

UROLOGY OF GREATER ATLANTA, LLC

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Primary Care MD: _____ Referring MD: _____

HISTORY OF PRESENT ILLNESS

Chief Complaint: _____

Where is the problem? _____

When does it occur? _____

For how long? _____

How severe? _____

What worsens or relieves it? _____

Associated symptoms: _____

MEDICAL HISTORY

Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth Defects
- ☐ Bladder Cancer
- ☐ Bladder Infections
- ☐ Bladder Problems
- ☐ Bleeding or Bruising
- ☐ Diabetes
- ☐ DVT/Blood Clots
- ☐ Epilepsy
- ☐ Gallbladder Problems
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Intestinal/Bowel Problems
- ☐ Kidney Infections
- ☐ Kidney Problems
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Problems
- ☐ MRSA/Staph Infection
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease
- ☐ Phlebitis
- ☐ Polio
- ☐ Prostate Cancer
- ☐ Prostate Problems
- ☐ Psychological problems
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Stroke/TIA
- ☐ Thyroid Problems
- ☐ Ulcer
- ☐ Tuberculosis
- ☐ Other Cancer_____

Other problems we should know about? _____

MEDICATIONS

List all medications you take, with or without prescription.

Medication	Dosage	Medication	Dosage

ALLERGIES

☐ No Known Drug Allergies ☐ Latex ☐ Contrast Dye

Describe any current or past drug allergies_____

Describe any current or past non-drug allergies_____

UROLOGY OF GREATER ATLANTA, LLC

SURGERIES AND HOSPITALIZATIONS

Have you had surgery or been hospitalized before? ☐ No ☐ Yes

Procedure	Year	Physician	Complications

FAMILY HISTORY

Please check all illnesses that apply to relatives and list relationship to you.

☐ Alzheimer's _____
☐ Arthritis _____
☐ Asthma _____
☐ Bladder Cancer _____
☐ Bladder Infections _____
☐ Diabetes _____
☐ Gout _____
☐ Heart Disease _____
☐ Kidney Cancer _____
☐ Kidney Infections _____
☐ Kidney Stones _____
☐ Osteoporosis _____
☐ Prostate Cancer _____
☐ Prostate Disease _____
☐ Stroke _____
☐ Sudden Death _____
☐ Other Cancer _____
☐ Other _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

Number of Children: _____ Occupation: _____

Smoking Status: ☐ Never Smoked
☐ Current Smoker: How often? ☐ Everyday ☐ Occasional Packs/day? _____
Year started smoking: _____
☐ Former Smoker: When did you quit? _____ How long did you smoke? _____

Alcohol Use: ☐ No
☐ Yes: How often? ☐ Daily ☐ Weekly ☐ Socially Type? _____

ADDITIONAL INFORMATION

Please use the space below to give us any additional information.

_____

_____

Patient Signature: _____ Date _____

Physician Signature: _____ Date: _____

UROLOGY OF GREATER ATLANTA, LLC

REVIEW OF SYSTEMS

Check if you are experiencing any of the following symptoms.

GENERAL:
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ None

EYES:
- ☐ Blurred vision
- ☐ Burning
- ☐ Cataract
- ☐ Double vision
- ☐ Glasses/Contacts
- ☐ Glaucoma
- ☐ None

HEMATOLOGIC:
- ☐ Ease of bleeding
- ☐ Ease of bruising
- ☐ Hepatitis
- ☐ Masses/nodules
- ☐ Wounds won't heal
- ☐ None

SKIN:
- ☐ Color change
- ☐ Hair loss
- ☐ Moles
- ☐ Lesion(s)
- ☐ Rash
- ☐ None

ENT:
- ☐ Discharge
- ☐ Dizziness
- ☐ Earache
- ☐ Hayfever
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Ringing
- ☐ Sore throat
- ☐ Voice change
- ☐ None

GASTROINTESTINAL:
- ☐ Bowel habit change
- ☐ Change in appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Pain
- ☐ Rectal bleeding
- ☐ None

PULMONARY:
- ☐ Coughing up blood
- ☐ Cough
- ☐ Oxygen Use
- ☐ Severe Snoring
- ☐ Shortness of breath
- ☐ Sleep Apnea
- ☐ Sputum
- ☐ Tuberculosis
- ☐ Wheeze
- ☐ None

NEUROLOGIC:
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizure
- ☐ Stroke
- ☐ Tingling
- ☐ Tremors
- ☐ Weakness
- ☐ None

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss
- ☐ Mood swings
- ☐ None

ENDOCRINE:
- ☐ Appetite change
- ☐ Diabetes
- ☐ Frequent urination
- ☐ Heat/cold intolerance
- ☐ Thirst
- ☐ None

MUSCULOSKELETAL:
- ☐ Joint swelling
- ☐ Muscle loss
- ☐ Pain
- ☐ Stiffness
- ☐ None

GENITOURINARY:
- ☐ Blood in urine
- ☐ Burning with urination
- ☐ Difficulty urinating
- ☐ Discharge
- ☐ Frequency of urination
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Pain when postponing urination
- ☐ Pelvic pain/pressure
- ☐ Sexual problems
- ☐ Sexually transmitted disease
- ☐ Unable to urinate
- ☐ Urgency of urination
- ☐ Urinary tract infection
- ☐ None

BREAST:
- ☐ Breastfeeding
- ☐ Lumps
- ☐ Discharge
- ☐ Pain
- ☐ Skin changes
- ☐ None

OB/GYN:
- ☐ Abnormal periods
- ☐ Birth control pill use
- ☐ Hot flashes
- ☐ Pregnant
- ☐ None

CARDIOVASCULAR:
- ☐ Chest discomfort
- ☐ Fainting
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Tightness
- ☐ None

_____
Patient or Guardian Name

_____
Relationship if other than self

_____
Signature

_____
Date

_____
Physician Signature

_____
Date

Urinary Leakage Questionnaire

Patient Name _____ **Date** _____ **Birthdate** _____

Do you leak urine? ☐ Yes ☐ No **If the response is no, skip to the next page**

Have you had surgery to treat the urine leakage? ☐ Yes ☐ No

How long have you leaked urine?

☐ Less than 1 Month ☐ 1 – 3 Months ☐ 3 – 6 Months ☐ 6 – 12 Months ☐ More than 1 year

When did the urine leakage start?

☐ After a surgery ☐ After Childbirth ☐ After a Stroke ☐ After an Injury ☐ After an Infection ☐ Unknown

How much urine usually leaks?

☐ Small amounts ☐ Large amounts

How often do you leak urine?

☐ Daily ☐ 1-2 times per week ☐ 1-2 per month

When does the urine leakage occur?

☐ Without warning ☐ While Sleeping ☐ During Intercourse ☐ Occasionally

What causes the urine leakage?

☐ Coughing ☐ Laughing ☐ Exercising

☐ Running Water ☐ Standing Up ☐ Putting a key in the door ☐ Infection

When urinating, can you stop your stream? ☐ Yes ☐ No

Are you bothered by a strong sense of urgency to void? ☐ Yes ☐ No

Do you wear protective pads? ☐ Yes ☐ No **If yes, how many per day?** 1 2 3 4 5+

Patient Name _____ Date _____ Birthdate _____

American Urological Association (AUA) Symptom Index

1)	**INCOMPLETE EMPTYING** Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
2)	**FREQUENCY** During the last month, how often have you had to urinate again less than 2 hours after you finished urinating?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
3)	**INTERMITTENCY** During the last month when you urinate, how often have you stopped and started again several times?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
4)	**URGENCY** During the last month, how often have you found it difficult to postpone urination?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
5)	**WEAK STREAM** During the last month, how often have you had a weak urinary stream?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
6)	**STRAINING** During the last month, how often have you had to push or strain to begin urination?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
7)	**NOCTURIA** During the last month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	Not at all **0**	Less than 1 time in 5 **1**	Less than half the time **2**	About half the time **3**	More than half the time **4**	Almost always **5**
	Totals for each column						

Total AUA Symptom Score (Add above column totals together) _____

AUA Symptom Score Scale: 1 – 7 Mild 8 – 19 Moderate 20 – 35 Severe

The Disease Specific Quality of Life Question

The international Prostate Symptom Score uses the same 7 question as the AUA Symptom Index (presented above) with the addition of the following Disease Specific Quality of Life Question (bother Score) scored on a scale from 0 to 6 points (delighted to terrible)

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	Delighted 0	Pleased 1	Mostly Satisfied 2	Mixed 3	Mostly disappointed 4	Unhappy 5	Terrible 6