

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 INDIAN 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
SUBSCRIBER'S SOC. SEC.# _____			SUBSCRIBER'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 | Hepatitis A | Peripheral Vascular Disease |
| Arthritis | Hepatitis B | Phlebitis |
| Asthma | Hepatitis C | Polio |
| Birth Defects | High Blood Pressure | Prostate Cancer |
| Bladder Cancer | High Cholesterol | Prostate Problems |
| Bladder Infections | HIV/AIDS | Psychological problems |
| Bladder Problems | Intestinal/Bowel Problems | Pulmonary Embolism |
| Bleeding or Bruising | Kidney Infections | Rheumatic Fever |
| Diabetes | Kidney Problems | Sexually Transmitted Disease |
| DVT/Blood Clots | Kidney Stones | Stroke/TIA |
| Epilepsy | Liver Disease | Thyroid Problems |
| Gallbladder Problems | Lung Problems | Ulcer |
| Gout | MRSA/Staph Infection | Tuberculosis |
| Heart Disease | Osteoporosis | 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 _____

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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 _____ Kidney Infections _____

Arthritis _____ Kidney Stones _____

Asthma _____ Osteoporosis _____

Bladder Cancer _____ Prostate Cancer _____

Bladder Infections _____ Prostate Disease _____

Diabetes _____ Stroke _____

Gout _____ Sudden Death _____

Heart Disease _____ Other Cancer _____

Kidney 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 _____

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

Ringling

GASTROINTESTINAL:

Bowel habit change

Change in appetite

Constipation

Diarrhea

Difficulty swallowing

Heartburn

Hemorrhoids

PULMONARY:

Coughing up blood

Cough

Oxygen Use

Severe Snoring

Shortness of breath

Sleep Apnea

Sputum

NEUROLOGIC:

Dizziness

Fainting

Headache

Numbness

Paralysis

Seizure

Stroke

Sore throat Nausea Tuberculosis Tingling

Voice change Pain Wheeze Tremors

None Rectal bleeding None Weakness None

PSYCHIATRIC:

ENDOCRINE:

MUSCULOSKELETAL:

GENITOURINARY:

Anxiety Appetite change Joint swelling Blood in urine
Depression Diabetes Muscle loss Burning with urination
Memory loss Frequent urination Pain Difficulty urinating
Mood swings Heat/cold intolerance Stiffness Discharge
None Thirst None Frequency of urination
None None None Incontinence

BREAST:

OB/GYN:

CARDIOVASCULAR:

Pain when postponing urination

Breastfeeding Abnormal periods Chest discomfort Pelvic pain/pressure
Lumps Birth control pill use Fainting Sexual problems
Discharge Hot flashes Palpitations Sexually transmitted disease
Pain Pregnant Shortness of breath Unable to urinate
Skin changes None Tightness Urgency of urination
None None None Urinary tract infection
None None None None

Patient or Guardian Name

Relationship if other than self

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+

Signature: _____

INTERNATIONAL PROSTATE SYMPTOM SCORE (IPSS) – MALE PATIENTS ONLY

Patient Name: _____ Birthdate: _____ Date: _____

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 International Prostate Symptom Score =

1-7 mild symptoms | 8-19 moderate symptoms | 20-35 severe symptoms.

Quality of Life (QoL)

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
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Have you tried medications to help your symptoms?	Yes	No
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Did these medications help your symptoms? (circle)									
1	2	3	4	5	6	7	8	9	10

No relief

Complete relief

Would you be interested in learning about a minimally invasive option that could allow you to avoid or discontinue enlarged prostate medications?	Yes	No
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Signature: _____