



Welcome to Urology Associates, P.C. This questionnaire is intended to be a COMPLETE account of your medical history. Please answer completely, including details and dates, if known. Incomplete answers to these questions could lead to improper treatment.

Chart: _____ Date _____

Name: _____ Nickname: _____ D.O.B: _____ Age: _____

Birth Sex: __Male __Female Preferred Pronoun Sex: __Male __Female __Gender Neutral

Identifies as: __Male __Female __Transgender: __Male to Female or __Female to Male __Non-Conforming Gender

Address (Street, City, State,Zip) _____

Home Phone: _____ Cell: _____ Work: _____

Occupation: _____ Primary Phone: (please circle one) Home / Cell / Work

Social Security#: _____ Marital Status: _____ Email: _____

Emergency Contact: _____ Relation to Patient: _____

Home: _____ Cell: _____ Work: _____

Referring Dr. _____ Primary Care Dr. _____

Other providers part of your care team: _____

Required Fields: Not Reporting Ethnicity: Hispanic or Latino Not Hispanic or Latino

Preferred Language: _____ Race: _____

Pharmacy Name, Address, Phone _____

Who referred you to see us today? __Hospital or Urgent care __ Primary care doctor __Other doctor __Self Referred

What problem or reason are you being seen for? _____

MEDICAL / PAST MEDICAL HISTORY Height: _____ ft _____ in Weight: _____ lbs

- ___ AFIB ___ Emphysema ___ History of Chemo ___ Thyroid Problems
___ Arthritis ___ Gastric Reflux ___ History of Radiation ___ Thyroid disease
___ Back Pain ___ Glaucoma ___ Kidney Failure ___ Urinary Tract Infections
___ Bladder Prolapse ___ Gout ___ Kidney Stone ___ Ulcers
___ Bleeding/clotting disorder ___ Heart Attack ___ Liver Disease ___ Uterine Prolapse
___ Cardiac Bypass ___ Heart Disease ___ Neuropathy ___ Vaginal Prolapse
___ Colon Problems ___ Heart Stent ___ Obstructive Sleep Apnea ___ Valve replacement
___ Chronic Kidney Disease ___ Hepatitis ___ Pacemaker
___ Diabetes Mellitus ___ Hernia ___ Pulmonary Embolism
___ Difficulty Urinating ___ Hypertension ___ Seizure Disorder
___ Deep Vein Thrombosis ___ Stroke/TIA

Other Medical Problems: _____

Pediatric Urologic History: _____

Urology Associates, P.C.

Patient Name: _____

DOB: _____

PAST SURGICAL HISTORY

Brain Intestine Fallopian Tubes Other Surgeries: _____
 Sinus Stomach Ovaries
 Thyroid Appendix Prostate **Do you have any replacement Joints?** No Yes:
 Lung Pancreas Testes Hip Knee Shoulder Heart Valves
 Hernia Kidney Penis
 Breast Bladder Vasectomy
 Gall Bladder Uterus Back

Please give details and dates of past surgeries checked:

HEALTH MAINTENANCE

When was your last: Flu shot? _____ COVID-19 Vaccine? _____ Pneumonia Shot? _____ Colonoscopy? _____

ALLERGIES Iodine Latex Shellfish No known medication allergies

Medication Allergies _____

CURRENT MEDICATIONS Do you take daily Aspirin? Yes No _____ I currently take no medications.

List Medications with dose

1. _____ 3 _____ 5 _____

2. _____ 4 _____ 6 _____

Additional medications _____

SOCIAL HISTORY Alcohol use per week _____ Caffeine use per day _____

Tobacco Use: Smoker: _____ packs per day Former Smoker: quit _____ years Never Smoked

Drug Use: _____

FAMILY HISTORY (please indicate family member diagnosed with the following)

M – mother, F – father, S – sister, B – brother, MG – maternal grandparent, PG – paternal grandparent

Bladder Cancer Bleeding/clotting disorder Liver Disease Urethral Stenosis
 Breast Cancer Diabetes Osteoporosis UTI's
 Colon Cancer Heart Disease Polycystic Kidney Disease Other:
 Kidney Cancer Hypertension Thyroid
 Pancreatic Cancer Kidney Disease
 Prostate Cancer Lynch Syndrome
 Testicular Cancer
 Ovarian Cancer

REVIEW OF SYSTEMS No symptoms at this time _____

Chills Weight Loss Swollen Glands Constipation Blood in Urine / Blood in Stool
 Fatigue Itching Cough Diarrhea Bleed Easily
 Fever Rash Shortness of Breath Nausea
 Sweating Dizziness Chest Pain Vomiting

Urology Associates, P.C.

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DOB: _____

BOWEL FUNCTION QUESTIONNAIRE

How often do you move your bowels?
___ times/day OR ___ times/week

Do you have trouble with constipation? Yes No

Do you ever have leakage of stool? Yes No

URINARY QUESTIONNAIRE

How often do you urinate? Every ___ hours during the day
I get out of bed ___ times a night

Do you lose urine in spurts with laughing, sneezing, or exertion? Yes No

What amount of urine do you lose? Small Large Both

In what position do you lose urine? Sitting Standing Lying down

Do you lose urine with a strong sense of urgency? Yes No

Does the sound, sight, feel of running water make you lose urine? Yes No

Do you lose urine without any warning (without activity or urgency)? Yes No

Do you wear a pad all the time? Yes No

Does your urine stream seem weak or slow? Yes No

Is it difficult to get the urine stream started? Yes No

Do you have pain associated with urination? Yes No

Do you feel that you empty your bladder completely? Yes No

Do you have frequent bladder infections? Yes No

(For Office Use Only)

REASON FOR VISIT: Was patient referred from another doctor or facility for this visit? No Yes =(use Transition In to Care ROV)

ASSESSMENT OF PLAN: ___Flow Rate ___Bladder Scan ___UA w/ micro ___Culture ___Cytology ___Lupron ___BCG

___Intron A ___Mitomycin BMI in range? Yes / No =(CQM folder) Tobacco: Current or Former? No Yes =(CQM folder)

Urology Associates, P.C.

Patient Name: _____

DOB: _____

HIPAA NOTICE ACKNOWLEDGEMENT

The Practice of Urology Associates, P.C. is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in providing our services to you. Such information may include documentation of your symptoms, examinations and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law, the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to use and disclose your PHI for the purposes of treatment, payment and health care operations without your written authorization.

We will use your PHI during the course of your treatment if the physician determines we will need to consult with a specialist in another area. He will share the information with the specialist and obtain his/her input. We will also use your PHI to contact you by phone, if we need to speak to you about a medical condition, or to remind you of medical appointments. We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. *** **Email**

Communications: Information stored on our computers is encrypted; however, most popular email services (e.g., Gmail, Hotmail, Yahoo, etc.) do not utilize encrypted email. As a result, when we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information. In addition, once the email is received by you, someone may be able to access your email account and read it. Email is a very popular and convenient way to communicate, so in a modification to the HIPAA act, the federal government provided guidance on email and HIPAA (this information is available at the U.S. Department of Health and Human Services website). We will only communicate via email using our secure email system.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We also want you to know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. You may revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office (except to the extent action has already been taken based on a previous authorization).

You have the right to receive the Notice of Privacy Practices for Protected Health Information from our office or visit our website at www.uradenver.com. I acknowledge that I have been given the option to receive a copy of the Notice of Privacy Practices for the practice of Urology Associates, P.C.

FINANCIAL SERVICE AGREEMENT

BILLING PRACTICES: Our policy is to bill the patient's insurance company for service rendered. However, Insurance coverage is another form of payment but ultimately it is your responsibility to pay for all services rendered. If you do not have insurance, payment is due at the time services are rendered. We will collect any known or estimated co-payments, co-insurance or deductibles at the time of service. Additionally, the responsible party will be billed for services rendered in full, should the insurance company deny coverage due to non-covered benefits, lack of referral, lack of proper reporting of incident/accident or lack of individual coverage, where applicable.

COLLECTION ACTIVITY: Any account balance(s) that are not paid within ninety (90) days from the date of service may be forwarded to a collection agency. If deemed necessary, Urology Associates PC reserves the right to forward the account balance(s) to a collection agency prior to ninety (90) days from the date of service. Any and all phone numbers provided to our office be it residential, employment or wireless, are authorized methods of communication by our office or by a collection agency in regards to any outstanding collection balances. Should litigation be necessary to collect an amount owed, the responsible party agrees to pay all costs of collection including, but not limited to, collection fees, attorney fees, interest and court costs.

PAYMENT FOR SERVICES: For payment of your financial obligation we accept Cash, Check, Visa, MasterCard or Discover.

If you have any questions or concerns, please speak with the billing dept. at (303)733-0662. **Please note: It is the patient's responsibility to understand their individual insurance benefits.**

I hereby assign to Urology Associates, PC all benefits for medical expenses. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I authorize the provider named above to release my medical records and all medical information requested by my insurance company.

Patient/POA/Auth.Agent Signature: _____ Date: _____

POA / Authorized Agent (Printed Name): _____

Urology Associates, P.C.

Patient Name: _____ **DOB:** _____

CONSENT TO CONTACT / LEAVE INFORMATION

I authorize Urology Associates and associated employees to speak with or leave a message regarding my appointments, medical conditions, test results, and or billing matters with the following individuals:

___ Myself on Home: _____ Cell: _____ Work: _____

___ Spouse/Partner: ___ ALL **or** ONLY: ___ Appointments ___ Medical Conditions ___ Test Results ___ Billing Matters

Name _____ Phone: _____

___ Family/Friend: ___ ALL **or** ONLY: ___ Appointments ___ Medical Conditions ___ Test Results ___ Billing Matters

Name _____ Phone: _____

___ POA / Agent: ___ ALL **or** ONLY: ___ Appointments ___ Medical Conditions ___ Test Results ___ Billing Matters

Name _____ Phone: _____

Patient Signature: _____ **Date:** _____

POA / Authorized Agent Signature: _____ **Date:** _____