Vitality Plus Urology Clinic

New Patient Paperwork

(Please Print)

Date:_____

Name:_____ Preferred: _____
First *MI* *Last*

DOB: _____ Sex (Please Circle) M F Social Security #: _____

Address: _____
City State Zip Code

Home # _____ Cell # _____ Work # _____

Preferred Communication: □ Call □ Text Primary Care Provider: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Race: *Check* □ American Indian/ Alaska Native □ Asian □ Black/ African American
□ White □ Native Hawaiian/ Pacific Islander □ Other

Ethnicity: *Check* □ Hispanic or Latino □ Not Hispanic or Latino

Primary Language: _____ Employer Name: _____

Patient Portal Information:

Vitality Plus Urology will communicate with you through our patient portal. This is how you will request prescription refills, communicate with our nurses and providers, and receive important education regarding any symptoms or conditions you may have. To sign up for the patient portal, please provide a valid email address that you check often, or please ask if you need assistance obtaining an email account.

E-Mail Address: _____

Emergency Contact:_____ Relation: _____ Phone#_____

Guarantor Information – *Person Responsible for Payment in the account (skip if same as patient)*

Name: _____ Address: _____

Phone: _____ Cell: _____

DOB:_____ Social Security #: _____

Home #_____ Cell #_____ Work #_____

Insurance

Primary Insurance Company: _____ Phone: _____

Insured SS#:_____ Policy Holder's DOB: _____

Secondary Insurance Company:_____ Phone: _____

Insured SS#: _____ Policy Holder's DOB: _____

HIPAA Notices of Privacy Practices

Authorized Methods of Communication:

1. Okay to leave a detailed message on answering machine/ voicemail? ☐ Yes ☐ No
2. Preferred phone number (Please check) ☐ Home ☐ Cell ☐ Work

Please list anyone authorized to access your medical records, treatment, details, and/or appointment info:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

I understand that the authorization for the release of information will be valid for one year from the date of this signature and can only be revoked upon written notice. I have received, read, and understand the Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of the practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, restrictions, but If you do not agree you are bound to abide by such restrictions. I hereby authorize all physicians participating in my healthcare and Vitality Plus Urology Clinic the release, use, and disclosure of my entire medical record by mail, phone, fax, and to carry out my treatment, payment, and healthcare operations. By signing below, I acknowledge that this form has been read in full and explained as necessary.

Patient Name (Please Print)	Date of Birth
Signature of Patient or Personal Representative	Date

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Vitality Plus Urology is committed to providing you with the best possible medical care. Our practice participates with a variety of insurance plans. As a courtesy to our patients, we submit all charges to the appropriate insurance companies and will do our best to answer any questions you may have. Specific coverage issues, however, should be directed to your insurance company.

It is your responsibility to:

- **Bring your current insurance card to every visit.** We consider an insurance card similar to a credit card because you are asking us to bill another party for the services you have been provided. If you do not bring your insurance card you should be prepared to pay for your services in full at the time of service.
- **Be prepared to pay your copay at each visit.** We are required by your insurance plan to collect copays the date of service. If you do not bring proper payment to your visit you may be required to reschedule your appointment, except in the case of a medical emergency.
- **Pay for self-pay services or any services/ amounts not paid by insurance at the time of service.** All non-covered services, as well as coinsurances and deductibles, are to be paid at check-in. Self-Pay services are to be paid for up front at the time of service. For your convenience, we accept Cash, Check, Visa, Master Card, Discover and Care Credit.
- **Pay in advance for surgical procedures.** If your physician recommends a surgical procedure you will be required to pay your portion of the fees in advance of the procedure. We will communicate with your insurance company to obtain authorization and benefit information.

Medicare Lifetime Signature on File (for Medicare patients)

I request that payment of authorized Medicare benefits be made on my behalf directly to this practice for any services furnished to me. I authorize the release of any medical or other information necessary for processing claims to the Center for Medicare and Medicaid Services.

Initial here: _____

Private Insurance Authorization for Assignment of Benefits/ Information Releases

I authorize the payment of medical benefits to be made on my behalf directly to this practice for any services furnished to me. I understand that I am financially responsible for any amounts not covered by my insurance contract. I authorize the release to my insurance company of any information concerning healthcare, advice, or treatment provided to me that is necessary for processing insurance claims. I further understand that I am responsible for any balance not covered by insurance. In the event that services are provided are denied as routine, preventive, pre-existing, or non-covered you will be responsible for the balance. I also understand it is my responsibility to obtain insurance referrals from my primary care physician if required by my insurance.

Initial here: _____

VA Patients

I authorize the payment of medical benefits to be made on my behalf directly to this practice for any services furnished to me. I also understand it is my responsibility to verify that a current authorization is on file. In the event that services provided are denied as routine, or non-covered you will be responsible for the balance.

Initial here: _____

Self Pay Patients

I understand that I am financially responsible any and all charges for my visit. I understand that many factors can affect the total bill such as injections, labs, and other items that are unknown until I am seen by the provider, therefore I cannot be provided with an exact quote for the charges due for my visit. I understand I am responsible for ANY and ALL charges for my visit. I agree to provide the correct phone number and mailing address so I can receive my bill. I understand that I may be denied further appointments if I do not pay my bill.

Initial here: _____

By signing below, I acknowledge that I have reviewed and understand the above practice policies.

_____ _____

Signature of Patient or Personal Representative Date

Late Arrivals and Missed Appointments:

We try very hard to be respectful of your time, and work diligently to stay on schedule. Our health care providers encounter many situations and emergencies that may cause them to need to spend extra time with a patient, and we will try to communicate with you if that occurs. Because we have so many patients waiting for appointments, it is very important that you arrive to your appointment on time with everything needed. If you are more than 15 minutes late, do not have your lab or imaging studies completed, or haven't completed your required paperwork, we may have to reschedule you to another time so that other patients can be seen in a timely manner.

Vitality Plus Urology maintains a waiting list for patients who need an appointment sooner than our next available time slot. It is very important that you let us know at least 24 hours in advance if you will not be able to keep to your scheduled appointment so that we can give that time to another patient.

To ensure that we are able to provide care for our patients, patients who fail to give the required 24 hour notice or arrive more than 15 minutes late to an appointment more than two times in one year may be dismissed from the practice and no further appointments will be scheduled. New patients who miss their first scheduled appointment may not be scheduled for another appointment. Repeated cancellations or missed appointments will result in loss of future appointment privileges, and a $25.00 fee for each missed appointment.

Patient Responsibilities:

We expect our staff and providers to treat you with courtesy and respect, and a strong working relationship requires cooperation on both sides. Your healthcare needs are best addressed in a safe and friendly environment. If you are unhappy with your care, please discuss it with your provider or the clinic manager. If we cannot resolve the conflict, it is in your best interest to find a provider that better meets your needs. Some examples of unacceptable behaviors that may result in dismissal from our practice are: displaying a hostile or threatening attitude, refusal to pay, and refusal to cooperate or follow recommended treatments or self-care plans.

PATIENT SIGNATURE DATE

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Reason for Appointment: _____

Pharmacy Name/ Location: _____

Medication List

Please List All Below

Drug	Dosage	Frequency	Reason for Medication

Allergies to Medications: ☐ Yes ☐ No

If yes please list Meds/ Allergies/Reactions: _____ _____

_____ _____ _____

Food Allergies ☐ Yes ☐ No

If yes please list Allergies/Reactions: _____ _____

_____ _____ _____

Allergic to Latex? ☐ Yes ☐ No

Any other known Allergies? Please Explain:

_____

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Other Physicians that Treat you

Specialty	Your Physician's Name	Specialty	Your Physician's Name
Primary Care		Eye Doctor:	
OB/GYN		Pulmonologist	
Gastroenterologist		Urologist (Past)	
Cardiologist		Other:	
Preferred Imaging Location		Preferred Lab Location	

Past Medical History: *Please Check All that Apply*

- ☐ Anxiety
- ☐ Arthritis (*Please check which applies below*)
  - Osteoarthritis
  - Psoriatic
  - Rheumatoid
- ☐ Cancer/ Type: _____
- ☐ Coronary Artery Disease (CAD)
- ☐ Degenerative Disc Disease
- ☐ Depression
- ☐ Diabetes (High Blood Sugar)
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Irritable Bowel Syndrome
- ☐ Low Thyroid
- ☐ High Thyroid
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Seizure
- ☐ HIV/ AIDS
- ☐ Stroke

Urologic History

- ☐ Abdominal/ Flank Pain
- ☐ Back Pain
- ☐ Blood in Urine
  - Microscopic
  - Gross (Visible)
- ☐ Burning with Urination
- ☐ BPH
- ☐ Difficulty Urinating
- ☐ Elevated PSA
- ☐ Erectile Dysfunction
- ☐ Incontinence (Leaking Urine)
  - Coughing
  - Sneezing
  - Cannot make it to the bathroom when you have the urge to go
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Waking to urinate at night
  - How many times a night_____
- ☐ Overactive Bladder
- ☐ Prostate cancer
- ☐ Prostatitis
- ☐ Renal Failure / Chronic Kidney Disease
- ☐ Urinary Frequency
- ☐ Urinary Tract Infection (UTI)
- ☐ Urinary Retention
- ☐ Urinary Urgency
- ☐ Urinary Stents

Male Patients

- ☐ Testicular Pain
- ☐ Problems with Sexual Desire
- ☐ Take medications to achieve your erections.
- ☐ Weak Stream
- ☐ Urine Starts and Stops

List Any Other Below:

_____

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Height: _____ **Weight**: _____

Past Surgical History: *Please make sure to list the dates for each surgery if there is more than one.*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Hospitalizations: *Please make sure to list the dates and reason.*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Social History

Alcohol Use: ☐ Never

☐ Former Age Started: _____ Age Stopped: _____

☐ Current # of drinks per day: _____

Tobacco Use: ☐ Never

☐ Former Age Started: _____ Age Stopped: _____

☐ Current Current / # of Packs/ Cigarettes per day: _____

Drug Use: ☐ Yes ☐ No

If yes, explain:

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Review of Systems

Do you now or have you had any problems relating to these systems? (please check the correct answer)

Constitutional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Other	_____	

Eyes

Blurred Vision	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Other	_____	

Ear/ Nose/ Throat/ Mouth

Ear Infection	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Other	_____	

Cardiovascular

Chest Pain	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Other	_____	

Respiratory

Wheezing	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Other	_____	

Gastrointestinal

Abdomen Pain	☐ Yes	☐ No
Nausea/ Vomiting	☐ Yes	☐ No
Indigestion/ Heartburn	☐ Yes	☐ No
Other	_____	

Genitourinary

Urine Retention	☐ Yes	☐ No
Painful Urination	☐ Yes	☐ No
Urinary Frequency	☐ Yes	☐ No
Other	_____	

Integumentary

Skin Rash	☐ Yes	☐ No
Boils	☐ Yes	☐ No
Persistent Itch	☐ Yes	☐ No
Other	_____	

Neurological

Tremors	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No
Numbness/ Tingling	☐ Yes	☐ No
Other	_____	

Musculoskeletal

Joint Pain	☐ Yes	☐ No
Neck Pain	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Other	_____	

Endocrine

Excessive Thirst	☐ Yes	☐ No
Too Hot/ Cold	☐ Yes	☐ No
Tired/ Sluggish	☐ Yes	☐ No
Other	_____	

Psychologic

Are you satisfied with life?	☐ Yes	☐ No
Do you feel severely depressed?	☐ Yes	☐ No
Have you ever considered suicide?	☐ Yes	☐ No
Other	_____	

Hematological / Lymphatic

Swollen Glands	☐ Yes	☐ No
Blood Clotting	☐ Yes	☐ No
Other	_____	

Allergic/ Immunologic

Hay Fever	☐ Yes	☐ No
Drug Allergies	☐ Yes	☐ No
Other	_____	

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

International Prostate Symptom Score (I-PSS) (***MALE PATIENTS ONLY***)

	Not at all	Less than 1 time in 5	Less than ½ the time	About ½ the time	More than ½ the time	Almost Always	Your Score
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**	
2. Frequency Over the past month, how often have you had to urinate again less than two (2) hours after you have finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**	
	None	1 time	2 times	3times	4 times	5 times	
7. Nocturia Over the past 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 this morning?	**0**	**1**	**2**	**3**	**4**	**5**	
Total-IPSS Score							
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
Quality of Life Due to Urinary Symptoms 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?	**0**	**1**	**2**	**3**	**4**	**5**	**6**

The International Prostate Symptom Score (I-PSS) is based on the answers to seven questions concerning urinary symptoms. Each question allows the patient to choose one of the six answers indicating increasing severity of the particular symptom. The answers are assigned points from 0-5. The total score can therefore range from 0-35 (asymptomatic to very symptomatic). Furthermore, the International Scientific Committee recommends the use of a question to assess the quality of life. The answers to this question range from "delighted" to "terrible", or 0-6. Although this single question may or may not capture the global impact or benign prostatic hyperplasia (BPH) symptoms or quality of life, it may serve as a valuable starting point for doctor-patient conversation.

The International Scientific Committee recommends that all physicians who counsel patients suffering from symptoms of prostatitis utilize these measures not only during the Initial interview, but also during and after treatment in order to monitor treatment response.

The International Scientific Committee, under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), has agreed to use the symptom index for BPH, which has been developed by the American Urological Association (AUA) Measurement Committee, as the symptoms assessment tool for patients suffering from prostatism.

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

FAMILY HISTORY: (Cancers, Diabetes, Heart Diseases, Pulmonary or Kidney Diseases, etc)

Family Member	Deceased? Cause of Death	Age	Medical Issues (If Cancer please list what type)
Father :			
Mother:			
Siblings:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			