WASHINGTON UROLOGY

Your appointment is on

_____ at _____.

Washington Urology utilizes an electronic chart system that requires all patient information to be entered prior to your appointment. In order to provide you with the best service at your appointment and decrease your wait time, your completed registration packet must be dropped off during office hours, mailed, or faxed to us as soon as possible but at least one week prior to your appointment. Please note, if you choose to return your registration by mail, you must add an additional $0.22 or an extra stamp to your envelope. Thank you in advance for allowing us to serve you better!

Office Hours:
Monday – Thursday 8:00 am – 5:00 pm
Friday 8:00 am – 12:00 pm

Office Location
471 Williams Blvd.
Richland, WA 99354
Mon, Wed, & Friday

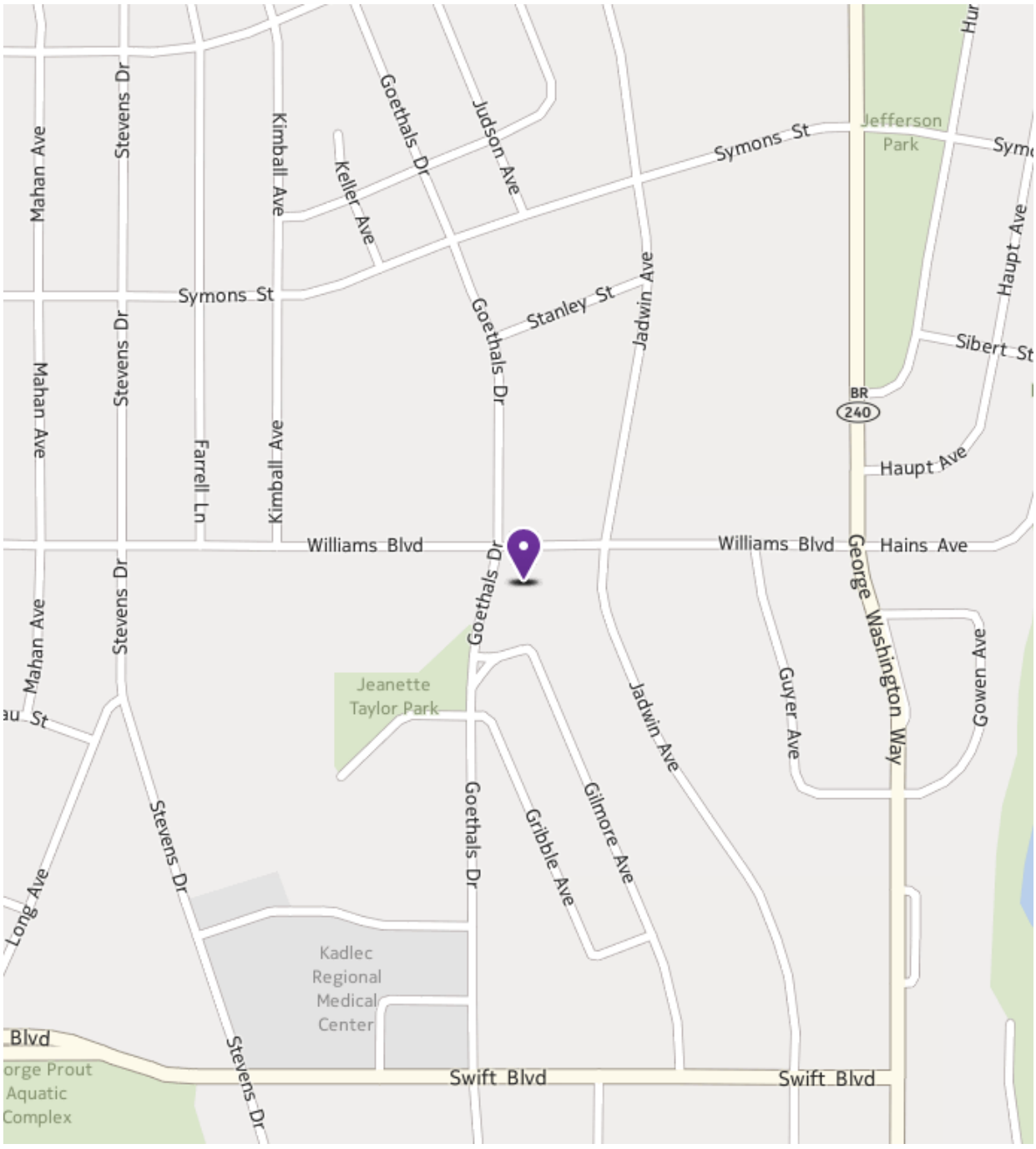
Phone: 509-946-8000
Fax: 509-946-8002

For all New Patients:

1. Please return your completed registration packet at least one week prior to your appointment.
2. Bring a list of medications, allergies, past medical history and/or surgeries and the name of your referring or primary care doctor.
3. Bring a picture ID, insurance cards and co-payment (if applicable). If you do not bring your insurance cards, your appointment will be rescheduled.
4. Contact your referring doctor's office to request your medical records and labs be faxed to our office at 509-946-8002.
5. Be prepared to give a urine sample when you arrive to your appointment.
6. If you have any questions, please call us at 509-946-8000.

Thank you!

Richland Office



Naeem T. Chavla, MD

Phone 509.946.8000
Fax 509.946.8002

471 Williams Blvd
Richland, WA 99354

Registration Form

Name: (Last) _____ (First) _____ Driver's Lic #: _____ SSN: ____-____-____
Address: _____ City:_____ State:_____ Zip:_____
Home Phone: _____Cell Phone: _____ Sex: M___F___ Birth date:____/____/____
Employer: _____
Business Address: _____ Business Ph._____
Email: _____ ☐ Interested in Patient Portal

Primary Language: _____ Race: _____ Ethnic Group: _____

Emergency Contact:
Name: _____Phone:_____

PRIMARY INSURANCE
Name of Person Responsible for Account: Last)_____(First)_____
Relation to Patient_____ Birth date:____/____/____SSN: ____-____-____
Address (if different from patient's) _____
City: _____ State: _____ Zip: _____ Phone_____
Person Responsible Employed by_____ Occupation: _____
Business Address: _____Business Phone_____
Insurance Co. _____Subscriber#_____Phone_____

ADDITIONAL INSURANCE? Yes_____ No_____
Name of Person Responsible for Account: (Last)_____ (First)_____
Relation to Patient_____ Birth date:____/____/____SSN: ____-____-____
Address (if different from patient's) _____
City: _____ State: _____ Zip: _____ Phone_____
Person Responsible Employed by_____ Occupation: _____
Business Address: _____Business Phone_____
Insurance Co. _____Subscriber#_____Phone_____

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Washington Urology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____ Relationship_____ Date____/____/____

Name: _____

History of Present Illness

Referring Doctor: _____Family Doctor: _____

Height: _____ Weight: _____

Why are you seeing the doctor today? _____
How long have you had this problem? _____
What improves or worsens the problem/pain? _____
Are there any symptoms that go along with the problem/pain? _____
Is the problem/pain continuous or does it come and go? _____
Describe the pain (sharp/dull, etc.) _____
Have you tried any medicine/treatment for this problem/pain? _____
Please list any labs or imaging ordered by your physician for this problem _____
Who was the ordering physician? _____

Have you received your flu shot for this year (Y / N) if no, why not? _____

CURRENT MEDICATIONS – Please list ALL medications you are currently taking including over the counter meds
Drug Name, strength, directions/how you take it:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Attach list if necessary.

Pharmacy Name/Location: _____Phone #: _____

ALLERGIES – Please list ALL types (Drug, seasonal, pets, environmental foods):

_____
_____
_____

By what method did you choose our practice:

Referring Physician _____Friend _____Yellow Pages _____Insurance Company _____Other_____

Name: _____

Past Medical History

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular
Anemia
Angina
Anorexia
Aortic Aneurysm
Aortic Regurgitation
Aortic Stenosis
Arrhythmia
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Enlarged Heart
Heart Attack
Heart Block
Heart Disease
Heart Murmur
Heart Valve Problem
Hemophilia
Hypertension, well controlled
Hypertension, progressive
Hypertension, severe
Leukemia
Mitral Insufficiency
Mitral Stenosis
Mitral Valve Prolapse
Rheumatic Fever
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia

Endocrine/Metabolic
Diabetes Mellitus, non-insulin dependent
Diabetes Mellitus, insulin dependent
Diabetes Mellitus, uncontrolled
Goiter
Gout
Hyperthyroidism
Hypothyroidism
Impaired Glucose Tolerance

General
Allergies
Electrical Injury
Exposure to Chemicals
Hepatitis A
Hepatitis B
Hepatitis C
Hypercholesterolemia
Hyperlipidemia
Infectious Disease
Lipid Disorder
Malaise
Obesity
Paget's disease
PCKD
PCO
Raynaud's Syndrome

GI
Cholecystitis
Cholelethiasis
Chronic Liver Disease
Colitis
Constipation
Colon Condition
Crohn's Disease
Diarrhea
Diverticulitis
Diverticulosis
GERD
Hemorrhoids
Hepatic Failure
Hepatitis
Hiatal Hernia
Inflammatory Bowel Disease
Liver Disease
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer
Ulcerative Colitis

GU
AIDS
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection
Chronic Renal Disease
Chronic Renal Insufficiency
Chronic Renal Failure
Crossed Fused Ectopia
Hematuria
Impotence of Organic Origin
Interstitial Cystitis
Irradiation Therapy
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones
Libido Decreased
Nephrolithiasis
Nephrotic Syndrome
Neurogenic Bladder
Orchitis
Penile Discharge
Polycystic Disease
Polycystic Kidney Disease
Prostate Cancer
Radiation or Nuclear Exposure
Recurrent UTI
Renal Cell Cancer
Renal Failure
Renal Insufficiency
Testicular Cancer
Transplant Recipient
Transitional Cell CA Bladder
Transitional Cell CA Ureter
Undescended Testicle (Birth)
Urinary Tract Infection
Venereal Disease

GYN/OB
Breast Cancer
Breast Disease
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Fibroids

HEENT
Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Menniere's
Mumps
Sinusitis
Tinnitis
Vertigo

Musculoskeletal
Arthritis
Back Pain
Carpal Tunnel Syndrome
Claudication
Fibromyalgia
Morton's Neuroma

Neuro/Psych
ADD
ADHD
Alcoholism
Alzheimer's Disease
Anxiety
Bi-polar Disorder
Chronic Fatigue Syndrome
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Organic Brain Syndrome
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt

Respiratory
Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia
Pulmonary Embolism
Tuberculosis

Name: _____

Tumors
Brain Cell Carcinoma
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Fibrocystic Breast Disease
Gastric Cancer
Laryngeal Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Rectal Cancer
Rectal Cell Cancer
Sarcoidosis
Testicular Cancer
Transitional Cell CA Bladder
Transitional Cell CA Ureter
Uterine CA

Other:_____
_____

Surgical History

Please CIRCLE if you have had any of the following surgeries and date of surgery:

Cardiovascular
Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery
Heart Surgery (Stents)
Heart Transplant
Pacemaker Insertion
Vein Stripping

General
Brain Surgery
Laminectomy
Lymphatic Node Dissection
Parathyroidectomy
Pilondial Cyst Incision
Skin Grafting

GI
Appendectomy
Bariatric Surgery
Bowel Resection
Cholecystectomy
Colon Resection
EGD
EGD/Dilation Esophagus
Fissurectomy
Gastric Surgery
Hemorrhoidectomy
Ileostomy
Laparoscopy
Liver Surgery
Liver Transplant
Lumpectomy of Breast
Lysis Adhesions
Nissen Fundoplication
Splenectomy
Stomach Surgery
Umbilical Hernia
Ventral Hernia Repair

GU
Bladder Surgery
Biopsy Prostate
Brachytherapy
Circumcision
Contigen
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy-Stent
Cysto-TUR Fulguration
Durasphere
Epididymectomy
ESWL
Herniorrhaphy
Hydrocelectomy
Ileal conduit
Indigo Laser Surgery
Inguinal Herniorraphy
InterStim
Kidney Stone
Laser Lithotripsy
Meatotomy
Needle Biopsy Prostate
Nephrectomy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Implant
Penectomy
Penile Surgery
Pyeloplasty
Radical Prostatectomy
Renal Transplant
Spermatocelectomy
TUMT Prostate
TUNA Prostate
TURBT
TUR Prostate
Ureteroscopy
Variocelectomy
Vasectomy
VLAP

GYN
Breast Implants
Breast Surgery
Cyst Removal
Delivery Vaginal
Delivery Forceps
Delivery Cesarean
Endometrial Ablation
Hysterectomy
Hysterectomy-Complete
Hysterectomy-Partial
Hysterectomy, Vaginal
Oophorectomy Unilateral
Oophorectomy Bilateral
Rectocele Repair
Tubal Ligation Bilateral

HEENT
Cataract Surgery
Corneal Surgery
Ear Surgery
Eye Surgery
Facial Surgery
Mastoid Surgery
Nasal Surgery
PEG
PE Tubes
Septoplasty
Sinus Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery

Musculoskeletal
Amputation
Arthroscopic Knee-Right Surgery
Arthroscopic Knee-Left Surgery
Back Surgery
Carpal Tunnel- Right Surgery
Carpal Tunnel- Left Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery- Right
Foot Surgery- Left
Hand Surgery- Right
Hand Surgery- Left
Hip Surgery- Right
Hip Surgery -Left
Knee Surgery- Right
Knee Surgery- Left
Leg Surgery- Right
Leg Surgery- Left
Rotator Cuff Surgery
Shoulder Surgery- Right
Shoulder Surgery- Left

Respiratory
Lung Surgery

Skin
Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

Other:_____
_____

Name: _____

Social History

Please provide the following information:

Marital Status: **Please indicate years**
Single ____Married ____Separated____ Divorced ____Widowed _____Life Partner _____Common Law Spouse_____

Dependants: **Please indicate # of each, if you have:**

Sons _____Daughters _____Stepchildren _____Adopted _____Foster _____Parents _____Grandparents_____
# of Pregnancies: _____ Currently Pregnant? Yes_____ No_____

Occupation: Please circle one that applies
None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time
Other_____ Are you retired? Yes_____ No_____

Hobbies: Please circle any that apply to you:
None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

Alcohol Consumption:
None _____Yes_____ Occasional/Social # of drinks per day _____

Tobacco per day:
None _____ Yes #_____ Packs/day _____Cigarettes/day _____ Smokeless Tobacco_____
If you previously stopped, When? _____

Recreational Drugs:
None_____ If yes, please list: _____

Caffeinated beverages:
On average, how many cups (8oz glasses) of the following liquids do you drink daily?
Coffee (reg or decaff)_____cups/day Soda_____ cups/day Tea _____cups/day
Juice _____ cups/day Water _____ cups/day Other _____cup/day

Recent Foreign Travel:
None _____ Americas _____ Worldwide _____

Family History

Please CIRLCE and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt)

Arthritis_____
Leukemia_____
Bedwetting_____
Malignant Melanoma _____
Bladder Cancer _____
Multiple Sclerosis_____
Cancer (site unknown)_____
Laryngeal Cancer_____
Crohn's Disease _____
Pancreatic Cancer_____
Depression_____

Prostate Cancer_____
Diabetes_____
Stroke _____
Gout _____
Thyroid Disease _____
Heart Attack _____
Tuberculosis _____
Hypertension _____
Kidney Cancer _____
Kidney Disease _____

Other: _____

Name: _____

Review of Systems

Constitutional
Appetite Changes
Anorexia
Aches and Pains
Chills
Easy Bruising
Fever
Fatigue
Generalized Weakness
Insomnia
Night Sweats
Sleep Apnea
Swollen Glands
Weight Gain
Weight Loss

Eyes
Blind
Blurred Vision
Double Vision
Glaucoma
Pain
Worsening Eyesight

Allergic/Immunologic
Animal Allergies
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

Neurological
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems
Tremors

Endocrine
Diabetes
Excessive thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too Hot/Cold

Gastrointestinal
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/heartburn
Irregular Bowel Movements
Nausea/vomiting
Rectal Bleeding
Tarry Stool

Cardiovascular
Chest Pain/Angina
Dyspnea on Exertion
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse
Orthopnea
Pain/Cramps Hips/Legs w/exercise
Palpitation
Skipped Heart Beats
Swelling

Skin
Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin rash

Musculoskeletal
Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness

Ear/Nose/Throat
Ear Infection
Sinus Problem
Sore Throat

Genitourinary
Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Enuresis
Not Emptying
Painful Ejaculation
Stranguria
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream

Respiratory
Asthma
Emphysema-Bronchitis
Environmental Allergies
Frequent Cough
Pneumonia
Shortness of breath
Tuberculosis
Wheezing

Hematologic/Lymphatic
Swollen Glands
Blood clotting problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell

Psychologic
Anxiety
Depressed
Generally satisfied with life

Other: _____

_____

_____

_____