

COMMONWEALTH UROLOGY

Patient Registration Welcome!

Patient Information Please Print Clearly

Appointment Scheduled with: Dr. Basile Dr. Patel

Today's Date: _____

New Patient

Update Info

Name: _____ Sex: **Male** **Female**
First MI Last

Address: _____
City State Zip Code

Email: _____ Home#: _____ Cell#: _____

DOB: _____ Age: _____ SSN: _____ Marital Status: **M S D W**

Employer: _____ Occupation: _____

Primary Care/Referring Physician: _____ Doctor #: _____

Pharmacy Name: _____ Pharmacy #: _____

Drug Reactions/Allergies: _____

Spouse Information

Name: _____ DOB: _____ SSN: _____
First MI Last

Work #: _____ Cell #: _____ Employer: _____

Insurance Information

PRIMARY: _____ Copay/Deductible: _____

Address: _____
City State Zip Code

Policy ID#: _____ Group#: _____

Policy Holder Name: _____ Relationship: _____ DOB: _____

Type of Insurance: **PPO HMO POS MC** Referral /Authorization Required: **Yes No**

SECONDARY: _____ Copay/Deductible: _____

Address: _____
City State Zip Code

Policy ID#: _____ Group#: _____

Policy Holder Name: _____ Relationship: _____ DOB: _____

Information Verified: _____

COMMONWEALTH UROLOGY

INSURANCE: REQUIRED PRIOR AUTHORIZATION FOR MEDICATIONS

Dear Patients:

Most insurance companies have made changes to your pharmacy medication plans. As of January 1, 2014 the majority of drugs that are brand name are now considered non formulary. This means that your **insurance company will not pay nor cover the cost for most Brand Drugs** and then we receive letters/forms from your pharmacy denying coverage payments. This is especially true for **ED drugs, BPH and Overactive Bladder drugs and more recently cancer treating medications (e.g. Lupron, Zoladex, BCG, Mutamicin, Eligard)**. If you are to get cancer treatments here, it is YOUR responsibility to contact your insurance company and make certain the payment for these medications will be covered – otherwise it will be YOUR responsibility to pay our office for the cost of these medications as well as the cost of the office visit.

If you receive notification of non coverage, the doctor is requesting that you contact your insurance company to get the Prior Authorization Forms. You may then either:

1. Make an appointment with your doctor and bring the forms to be filled out.
2. You may fax us the prior authorization forms to be filed out for a \$20.00 fee payable in advance (non refundable fee.) *There is no guarantee that even if the doctor fills out the prior authorization forms that your insurance will pay for your medications.
3. Request your insurance company to fax YOU the list of approved formulary drugs. Then, make an appointment and bring in the list of approved formulary medications and the doctor will discuss with one may best treat your condition and then prescribe the medications for you.

Print Name: _____ Date: _____

Signature: _____

AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to my dependent or me during the period of such care to third party payers and/or healthcare practitioners. I also authorize and request my insurance company to pay directly to the doctor or to John J. Basile, M.D., P.C. (doing business as Commonwealth Urology) benefits otherwise payable to me.

I understand that if my insurance plan requires a **referral from** my primary care physician, **that it is my responsibility** to obtain it; otherwise, I agree that I am responsible for payment at the time of visit. I certify that the information I have reported with regard to my insurance coverage is correct and that if my insurance plan changes, that I will promptly notify the doctor's office of such change. I also agree to pay for services rendered which are not covered under my insurance plan. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

Print Name: _____ Date: _____

Signature: _____

(Patient, Parent or Guardian)

COMMONWEALTH UROLOGY

NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how medical information about you may be used, disclosed and how you can gain access to this information. A Federal Regulation, known as the "Health Insurance Portability & Accountability Act (HIPAA)", requires that we provide notice in writing of our privacy practices. These privacy practices are in place to maintain the privacy of your protected health information (PHI). Commonwealth Urology may disclose PHI for the purposes of treatment, payment, and to operate the practice. The following are some examples, and do not imply an exclusive list.

Examples of uses and disclosures for treatment: If the doctor refers you to another physician for continuation of treatment, we may provide your name and the reason for your referral to the doctor's office. The doctor or his staff may call you to advise you of treatment alternatives or recommendations.

Examples of uses and disclosures to obtain payment: Our billing office may submit a claim that contains your name, address, social security number, diagnosis, and procedure(s) performed by our physicians to your insurance company.

Examples of uses and disclosures to operate the practice: Our staff may call you or email you with reminders and leave messages about upcoming appointments, our staff may leave messages for you on your telephone and/or ask you to return the call, the physicians may audit (read and comment upon) your chart to track and improve our performance in assuring that we perform screening test on time.

Commonwealth Urology is permitted or required to use or disclose PHI without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements and court orders.

Commonwealth Urology will not make any other disclosure of your PHI, other than for the aforementioned purposes of treatment, payment, or practice operation, without the individual's written authorization. Such authorization may be revoked by you at any time. Revocation must be in writing.

You have the following rights regarding your PHI, and the practice must act on your request within 60 days: You may request restrictions on certain uses and disclosures of PHI, but we are not required to agree to a requested restriction, you may request to inspect and copy your own PHI, you may request that your information be amended, you may request a paper copy of this notice.

If you would like to authorize us to release your medical information to someone other than yourself, please complete the following: I authorize Commonwealth Urology to release confidential medical information pertaining to my care to the following people. I understand that it is my responsibility to notify Commonwealth Urology in writing, if this authorization information changes.

This HIPPA Form will allow confidential medical information to be obtained by my: (list names)

Spouse: _____ Parent(s): _____

Son/Daughter: _____ Other: _____

If No one (Put a check here): _____

Patient/Guardian Signature

Printed Name

Date

PATIENT HISTORY FORM

Patient Name: _____

Date: _____

CHIEF COMPLAINT

State, as clearly as possible, the main reason for your visit.

HISTORY OF PRESENT ILLNESS

Elaborate on your chief complaint.

Please Specify if you have had any of the following:

Urinary Tract Infections
Specify: _____

Kidney Stones
Specify: _____

Sexually Transmitted Disease
Specify: _____

Cancer of the Urinary Tract (kidney, bladder, prostate, or testicle)
Specify: _____

Prostatitis
Specify: _____

Incontinence
Specify: _____

Erectile Dysfunction
Specify: _____

Infertility
Specify: _____

PAST MEDICAL HISTORY

List all personal past illnesses with dates of diagnosis.

Illness:	Date:	Illness:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST SURGICAL HISTORY

List all surgical procedures you have undergone with dates.

Surgery:	Date:	Surgery:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS

List all medications you are currently taking with doses.

Medication:	Date:	Medication:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take aspirin, Ibuprofen, or any product that contains them? Yes No
If yes, when was the last time you took it? _____

Do you take Coumadin or any other type of blood thinner? Yes No
If yes, when was the last time you took it? _____

ALLERGIES

List all drugs to which you are allergic and your specific reaction to them.

Drug:	Reaction:	Drug:	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to Iodine? Yes No
If yes, how do you react to it? _____

Are you allergic to shellfish? Yes No
If yes, how do you react to it? _____

SOCIAL HISTORY

What is your occupation? _____

Do you smoke? Yes No

If yes, how much, and for how long? _____

Do you drink alcohol? Yes No

If yes, what type, how much, and for how long? _____

FAMILY HISTORY

List all serious illnesses in your immediate family, and the family member affected.

Illness:	Family Member:	Illness:	Family Member:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REVIEW OF SYMPTOMS

Please indicate if you have had any problems related to the following systems:

Constitutional Symptoms

Fever Yes No
Chills Yes No
Headache Yes No
Other: _____

Eyes

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

Allergic/Immunologic

Hay Fever Yes No
Drug Allergies Yes No
Other: _____

Neurological

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

Endocrine

Excessive Thirst Yes No
Too hot/cold Yes No
Tired/sluggish Yes No
Other: _____

Gastrointestinal

Abdominal Pain Yes No
Nausea/Vomiting Yes No
Indigestion/Heartburn Yes No
Other: _____

Cardiovascular

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

Integumentary

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

Musculoskeletal

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

Ear/Nose/Throat/Mouth

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

Genitourinary

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

Respiratory

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

Hematologic/Lymphatic

Swollen Glands Yes No
Blood Clotting Prob. Yes No
Other: _____

Psychologic

Feel Depressed Yes No
Considered Suicide? Yes No
Other: _____

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If you are a male patient and have difficulty urinating, please complete the questionnaire on the next page.
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