NASHVILLE UROLOGY

PATIENT REGISTRATION

Patient Information:

Last Name:_____First Name:_____MI: _____

Current Address: _____

City:_____State:_____Zip: _____

Home Phone:_____Cell Phone: _____

E-mail Address:_____SSN# _____

Date of Birth:_____Sex: ☐ M ☐ F

Referring Physician: _____

Primary Care Physician: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Financial Party Responsible/Guarantor:

Last Name:_____First Name:_____MI: _____

Current Address: _____

City:_____State:_____Zip: _____

Home Phone:_____Cell Phone: _____

SSN#:_____Date of Birth: _____

Relationship of Guarantor to Patient: _____

Insurance Information: Please present ID and Insurance cards to receptionist at the time of visit

Primary Insurance Name: _____

Secondary Insurance Name: _____

_____

NASHVILLE UROLOGY

GENERAL CONSENT FORM

Patient Name _____ **DOB** _____

Assignment of Benefits. I authorize Nashville Urology, P.C. to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that Nashville Urology, P.C. will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment. I consent for Nashville Urology, P.C, to administer medical care and services, including, but not limited to, diagnostic tests, examinations, administration of medication, and other medical procedures which are, in the judgment of a practitioner, necessary for the diagnosis and treatment of my illness or condition. I understand that no one connected with Nashville Urology, P.C. makes, or has made, any guarantees or representations of any kind or nature, express or implied, with respect to the conclusions, decisions, or outcomes of the medical procedures.

Patient Initials: _____

Electronic Prescription. I understand Nashville Urology utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Electronic Communication. I agree that the contact information I give to Nashville Urology, PC such as telephone numbers and email addresses, may be used by Nashville Urology and any third party acting on behalf of them to communicate with me via text message, phone call, or email for operational purposes including appointment follow up, treatment reminders, and patient feedback requests.

Patient Initials: _____

Phone Calls. By providing contact information, I authorize Nashville Urology, P.C., its assignees, and third-party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/ cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of others in Care. I authorize Nashville Urology, P.C. to discuss my/the patient's care and medical needs with the following persons:

NAME	Date of Birth	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** _____

May we contact you by phone and leave a message about your care?

Primary Phone: _____

☐ Leave message with contact number only
☐ Leave message with detailed information
☐ Do not leave message

Secondary Phone: _____

☐ Leave message with contact number only
☐ Leave message with detailed information
☐ Do not leave message

Patient Financial Policy.

I acknowledge receipt of the "Patient Financial Policy." **Patient Initials:** _____

Notice of Privacy Practices.

I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** _____

Do you have any of the following in place?

◯ **Do Not Resuscitate Order** ◯ **Living Will** ◯ **Power of Attorney**

NASHVILLE UROLOGY

REVIEW OF SYSTEMS

Patient Name _____ **DOB** _____

Check if you are CURRENTLY experiencing any of the following symptoms. Mark Yes or No for each selection.

CONSTITUTIONAL

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Weight gain over 10 lbs	☐ Yes	☐ No
Weight loss over 10 lbs	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No

NEUROLOGICAL (nervous system)

Seizures	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Numbness in extremity	☐ Yes	☐ No
Weakness in extremity	☐ Yes	☐ No
Loss of balance	☐ Yes	☐ No
Frequent falls	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

ENDOCRINE (internal glands)

Excessive thirst	☐ Yes	☐ No
Cold or heat intolerance	☐ Yes	☐ No
Excessive fatigue	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Hot flashes or night sweats	☐ Yes	☐ No

GASTROINTESTINAL

Abdominal pain	☐ Yes	☐ No
Nausea vomiting	☐ Yes	☐ No
Indigestion / Heartburn	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

CARDIOVASCULAR

Chest pain, pressure	☐ Yes	☐ No
Palpitations / Arrhythmia	☐ Yes	☐ No
Wake up breathless	☐ Yes	☐ No
Swelling in legs/ ankles	☐ Yes	☐ No
Uncontrolled Hypertension	☐ Yes	☐ No

MUSCULOSKELETAL

Joint pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Joint Laxity	☐ Yes	☐ No

RESPIRATORY (lungs)

Wheezing	☐ Yes	☐ No
Frequent coughing	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

HEMATOLOGIC / LYMPHATIC

Swollen lymph glands	☐ Yes	☐ No
Bleeding tendency	☐ Yes	☐ No
History of Blood Clots	☐ Yes	☐ No

GENITOURINARY (urinary and genital)

Painful urination	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Urgent urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Weak urine stream	☐ Yes	☐ No
Straining to urinate	☐ Yes	☐ No
Interrupted urine flow	☐ Yes	☐ No
Incontinence / Bladder leakage	☐ Yes	☐ No
Incomplete emptying	☐ Yes	☐ No
Nighttime Urination	☐ Yes	☐ No
Sexual dysfunction	☐ Yes	☐ No
Vaginal Pain	☐ Yes	☐ No
Vaginal Burning	☐ Yes	☐ No

EYES

Dry eyes	☐ Yes	☐ No
History of glaucoma	☐ Yes	☐ No

EAR/NOSE/THROAT/MOUTH

Dry Mouth	☐ Yes	☐ No

PSYCHOLOGICAL

Depression	☐ Yes	☐ No
Substance abuse	☐ Yes	☐ No
Severe anxiety	☐ Yes	☐ No

HEALTH MAINTENANCE

Last Menstrual Period	<1mo	1-6mo	6-12mo	>1yr	Never
Last Pap Smear	<1yr	1-3yr	3-5yr	>5yr	Never
Last Mammogram	<1yr	1-3yr	>3yr	Never	
Last Colonoscopy	<1yr	1-5yr	5-10yr	Never	

Pneumococcal Vaccine YES or NO

Where did you receive this Vaccine?

_____

NASHVILLE UROLOGY

MEDICAL HISTORY

Patient Name _____ **DOB** _____

EMAIL ADDRESS

Patient Email Address: _____

CURRENT MEDICATIONS

List all medications you currently take including vitamins, herbal supplements, and over-the-counter medications. If needed, attach an additional sheet.

Name of Medication	Dose (mg)	How often is the medication taken	Reason for taking medication	Physician prescribing
1				
2				
3				
4				
5				

PHARMACY

List pharmacy most frequently used for prescriptions.

Name_____Phone_____Fax_____

Address_____

City/State/Zip_____

Mail Order Pharmacy _____

ALLERGIES

List any allergies and reactions you have. Attach extra sheet if necessary.

Name of Allergen	Name of Allergen
1	4
2	5
3	6

PAST SURGERIES

Include all surgery in your lifetime. Attach extra sheet if necessary.

Type of Surgery	Type of Surgery
1	6
2	7
3	8
4	9
5	10

NASHVILLE UROLOGY

MEDICAL HISTORY

Patient Name _____ **DOB** _____

CHECK ANY PAST MEDICAL PROBLEMS:

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer; Type _____
- ☐ Chronic UTIs
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Enlarged Prostate
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Neurologic Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ _____
- ☐ Thyroid Disease
- ☐ Valvular Heart Disease

Other

CHECK ANY FAMILY HISTORY OF DISEASE:

Adopted? ☐ **Y** ☐ **N**

- ☐ Diabetes
- ☐ Enlarged Prostate
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Cancer
- ☐ Stroke
- ☐ Urinary Tract Infections
- ☐ Cancer, Other
- ☐ Other _____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Current ☐ Former ☐ Never Type: _____ Year quit: _____

Caffeine: ☐ Y ☐ N Type: _____ Amount per day: _____

Alcohol: ☐ Y ☐ N ☐ Former

Type: _____ Frequency: _____ Amount: _____ Last Drink: _____

Pregnancies: Number of Live Births: _____ Vaginal _____ C-Section: _____

Sexual Activity: Are You Sexually Active: ☐ Y ☐ N

Any issues/concerns you would like to discuss today? ☐ Y ☐ N _____

NASHVILLE UROLOGY

FINANCIAL POLICY

PLEASE READ PRIOR TO RECEIVING SERVICES

Nashville Urology, P.C. recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

Participating Provider: Before receiving services, you must verify that we are participating providers for your insurance company or plan. In the event that we are not participating providers with your insurance company or plan, we will file an initial claim as a courtesy. Payment, however, is due in full at the time of service. It is also your responsibility to verify any labs, imaging centers, hospitals or other services are participating providers for your insurance company or plan.

Payment: Payment is expected at time of visit whether you have a copay or deductible plan. Every insurance policy is different please consult with your insurance company to determine if your diagnostic tests will be covered. There will be an additional $20 charge for co-payments and deductibles not received at time of service.

Insurance Plans: We will bill your insurance company for services received by you at our office. To properly bill your insurance company, we require that you provide all insurance information including primary and secondary insurance, as well as any change of insurance information. You are expected to present an insurance card at each visit. Copayments and past due balances are due at time of check-in unless previous arrangements have been made with our billing department.

Payment for known copays, co-insurance, and deductibles are your responsibility, and will be due at the time services are performed. Not all services provided by this office are covered by every plan. You are responsible for understanding your benefit plan and for knowing its requirements for referrals to specialists, preauthorization of procedures, etc. It is your responsibility to pay for non-covered services. After insurance claims are paid, remaining balances on your account are your responsibility to be paid in full, within the regularly scheduled billing cycle of 30 days.

Self Payment (Private, Cash Payment): If you have no insurance coverage, we ask that you coordinate your care with our office prior to your visit. We require payment in full for professional services.

Returned Check Fee: A Returned Check fee of thirty-five dollars ($35) will be assessed to the patient account per incident.

Statements: We will send a statement (to the billing address you provide) notifying you of any balance you may owe. It is your responsibility to notify our office of any changes in your address, name, telephone, insurance information, etc. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business within 30 days after receipt of the initial statement. You can call 615-476-9018.

Missed Appointments: Nashville Urology requires 24-hour notice of appointment cancellation. Appointments missed and are not previously canceled may be charged a fee of $25.00 for office visits and $50.00 for in-office procedures.

Failure to keep your account balance current may require us to cancel or reschedule your appointment. Financial needs are understood by this office, please ask to speak with our billing department to discuss a mutually agreeable payment plan, or information on additional resources that maybe available.

If you have any questions about our fees, our policies, or your responsibilities, our billing department is available at 615-476-9018 and happy to assist.

Patient Name (Print) _____ DOB: _____

Patient Signature: _____ Date: _____