Providence Medical Park / 3841 Piper Street, Suite T300 / Anchorage, AK 99508
Alaska Regional Campus / 2925 DeBarr Road, Suite 250 / Anchorage, AK 99508
Ph: (907)-563-3103 F: (907)-561-1862

Mat-Su Regional Medical Plaza / 2490 S. Woodworth Loop, Suite 401 / Palmer, AK 99645
Ph: (907)-745-9300 Fax: (907)-745-9301
www.alaskaurology.com

PATIENT INFORMATION RECORD

Title: (please circle) **Mr.** **Mrs.** **Ms.** **Dr.** other: ___________ **Suffix:** **I** **II** **III** **IV** **Jr.** **Sr.**

Last Name: ___________________________ First Name: _______________________ Middle Name: ________________

Preferred Name: _____________________ Maiden Name: ____________________ Date of Birth: ____ / ____ / ____

Referred by: ___________________________________ Primary Care Physician: ______________________________

Preferred Pharmacy: ____________________________ Pharmacy Location: __________________________________

SEX: Male ________ Female ________ Other: ________ Age: _______ Marital Status: **M** **W** **D** **S**

Race: ______________________ Ethnicity: ___________________ Primary Language: _______________________

Physical Address: ______________________________________ City: ____________________ State: _____ Zip: _______

Mailing Address: ______________________________________ City: ____________________ State: _____ Zip: _______

Home Phone: (_______)________-_________ * Is it ok to call you at this number? **Y** **N** Leave a message? **Y** **N**

Work Phone: (_______)________-_________ * Is it ok to call you at this number? **Y** **N** Leave a message? **Y** **N**

Cell Phone: (_______)________-__________ * Is it ok to call you at this number? **Y** **N** Leave a message? **Y** **N**

Preferred Method of Communication: Home Work Cell Other: ________________________________

E-mail Address**:** ____

Employer: ____________________________ Occupation: ____________________________ Date of Hire: __________

In case of Emergency, contact: Last Name: ___________________________ First Name: ________________________

Emer. Contact Phone# (______)_______-_______ Date of Birth: ____ / ____ / ____ Relationship: ______________

INSURANCE INFORMATION

Is this related to a Work Comp claim? **Y**es _____ **N**o _____ -or- Motor Vehicle Accident? **Y**es _____ **N**o _____

Primary Insurance Carrier: _________________________ Policy Holder: Last_____________ First ___________ MI __

Insurance ID#: ___________________________________ Group#:_______________ Policy Holder DOB: ___________

Secondary Insurance Carrier: ______________________ Policy Holder: Last_____________ First ___________ MI __

Insurance ID#: ___________________________________ Group#:_______________ Policy Holder DOB: ___________

----- Please see reverse side -----

PRESCRIPTION HISTORY CONSENT

For safe, effective medication prescribing, Electronic Health Records enables us to identify all of your current medications electronically. Alaska Urology automatically utilizes electronic prescriptions to and from pharmacies. Your consent is automatically authorized unless you sign below to OPT out.

____ _________________________
Signature *Opting out* of Electronic Prescriptions Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Alaska Urology and its employees, agents or associated healthcare practitioners to disclose my protected health information to the following individuals:

Name ____________________	Name ____________________
Date of Birth ________________	Date of Birth ________________
Phone ____________________	Phone ____________________
Relationship ________________	Relationship ________________

PATIENT CONSENT/ASSIGNMENT: I hereby authorize Alaska Urology to release any information acquired in the course of my treatment to/from my insurance company, physician's office, hospital or any other treatment facility. I agree to be fully responsible for all expenses incurred for medical treatment. I assign to Alaska Urology any and all insurance benefits due to me, the full financial obligations for medical treatment that I have not paid for.

Printed Name: __________________ **Signature:** __________________ Date: ________

IF the above patient is a **CHILD**, has a **SPOUSE**, has a **LEGAL GUARDIAN**, or is **NOT RESPONSIBLE FOR THE BILL, PLEASE COMPLETE** the information requested in the section below:

Please check one:

☐ **Parent of Child** ☐ **Spouse** ☐ **Legal Representative** ☐ **Party responsible for the bill**

Last Name: ________________ First Name: ________________ Middle Name:____________

Preferred Name: ____________ Maiden Name: ____________ Date of Birth: ____________

SEX: Male _____ Female _____ Other: _____ Age: _____ Marital Status: **M W D S**

Physical Address: ____________________ City: ____________ State: ___ Zip: _____

Mailing Address: ____________________ City: ____________ State: ___ Zip: _____

Home Phone: (____)____-_____ Work: (____)____-_____ Cell: (____)____-_____

E-mail Address: ____

Employer: ________________________ Occupation: __________________

ALASKA UROLOGY

Medical History Sheet

Patient Name: ______________________________ **Date of Birth:** ______________________________

General Physician: ______________________________ **Referring Physician:** ______________________________

Reason for Today's Visit: ____

Medical History: (please mark all you have __ever__ been treated for or are __currently__ being treated)

- ❑ No Medical History

General

- ❑ Bleeding Disorder
- ❑ Glaucoma
- ❑ HIV/AIDS
- ❑ MRSA
- ❑ Rheumatic Fever
- ❑ Systemic Lupus Erythematosus
- ❑ Transplant Recipient, Organ:_____________

Cardiovascular

- ❑ Aortic Abnormality:____________________
- ❑ Atrial Fibrillation
- ❑ Blood Transfusion, Date:________________
- ❑ Congestive Heart Failure
- ❑ Coronary Artery Disease
- ❑ Clot in Leg or Lung
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Valve Disorder, Type:_____________
- ❑ High Blood Pressure

Endocrine/Metabolic

- ❑ Diabetes
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Low Testosterone

Respiratory

- ❑ Asthma
- ❑ COPD
- ❑ Emphysema
- ❑ Sleep Apnea
  - ❑ Use CPAP

Gastrointestinal

- ❑ Acid Reflux/GERD
- ❑ Crohn's Disease
- ❑ Hepatitis
- ❑ Stomach Ulcer
- ❑ Ulcerative Colitis

Genitourinary

- ❑ Chronic Kidney Disease
- ❑ Genital Herpes
- ❑ Genital Warts
- ❑ Interstitial Cystitis
- ❑ Kidney Stones
- ❑ Renal Failure
- ❑ STD:_____________________________
- ❑ Urinary Tract Infections

Men's Health

- ❑ BPH
- ❑ Hydrocele/Spermatocele
- ❑ Prostatitis

Women's Health

- ❑ Endometriosis
- ❑ Uterine Fibroids

Musculoskeletal

- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Chronic Back Pain
- ❑ Fibromyalgia
- ❑ Gout

Neuro/Psych

- ❑ Alzheimer's Disease
- ❑ Anxiety
- ❑ Parkinson's Disease
- ❑ Multiple Sclerosis
- ❑ Psychiatric Diagnosis:___________________
- ❑ Spinal Cord Injury, Level:_______________
- ❑ Stroke/TIA

Cancer

- ❑ Bladder
- ❑ Colon/Rectal
- ❑ Female, Type:_________________________
- ❑ Kidney
- ❑ Penile
- ❑ Prostate
- ❑ Testicular
- ❑ Other:______________________________

Other Medical History:____

____

Please complete back side

Immunizations:

Is the patient up to date on immunizations? Yes No

Female Health History:

Date of Last Menstrual Period:______________ Post-Menopausal: Yes No

Pregnancies#_____ Live Births#_____ Abortions (elective or spontaneous)# ____

Male Health History:

Date of Last PSA:___________

Date of Last Prostate Exam:____________ Normal_____ Abnormal_____

Recent Studies or Labs:

What: __________________________ Where:_______________________________________ Date: ____________

What: __________________________ Where: _______________________________________ Date: ___________

Surgical History: (please list ALL surgeries you have ever had) *if additional space needed, please ask.

Vasectomy Date: ____________ Hysterectomy Date: ___________

____ **Date:** __________________________

____ **Date:** __________________________

____ **Date:** __________________________

Family History: (please list type of cancer) *if additional space needed, please ask

Condition	*Relative(s)*	*Age of Diagnosis*	*Living/Passed*
Cancer:			
Cancer:			
Diabetes			
Heart Attack			
Heart Disease			
High Blood Pressure			
Kidney Stones			
Kidney Failure			
Other:			

Social History: (circle or fill in appropriate response)

Marital Status:

____Single ____Divorced # of Children:___________

____Married ____Widowed

Current Alcohol Consumption: No Yes _________drink per day

History of Alcohol Abuse: No Yes _________ days/months/years sober

Current Tobacco Use: No Yes cigarettes/cigars/chew _________packs per day

History of Tobacco Use: No Yes Age start? _________ Age stop? _________

Recreational Drug Use:

____None ____Current, name substance(s)____

____Former, name substance(s)____ _____days/mos/yrs sober

Daily Fluid Intake:

________ 8 oz. cups of coffee per day ________ 8 oz glasses of water per day

________ 8 oz. glasses of tea per day

________ 8 oz. glasses of milk per day

Patient Signature: ____ **Date:** ___________________________

Nurse/MA Signature: ____ **Date:** ___________________________

ADULT REVIEW OF SYSTEMS

1. **Constitutional Symptoms**

Fever	No	Yes
Chills	No	Yes
Unexplained change in weight	No	Yes

2. **Cardiovascular**

Chest pain	No	Yes
Irregular heartbeats	No	Yes
Leg Swelling	No	Yes

3. **Respiratory**

Shortness of breath on exertion	No	Yes
cough	No	Yes
TB exposure	No	Yes

4. **Gastrointestinal**

Nausea	No	Yes
Vomiting	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Abdominal Pain	No	Yes

5. **Genitourinary**

Urgent need to urinate	No	Yes
Do you void > 6 times a day ?	No	Yes
Do you void > 2 times at night ?	No	Yes
Painful urination	No	Yes
Visible blood in urine	No	Yes
Involuntary loss of urine	No	Yes
- related to urgency	No	Yes
- related to cough, sneeze	No	Yes
Unable to urinate	No	Yes
Urine slow to start	No	Yes
Weak urinary stream	No	Yes
Dribbling after urinating	No	Yes
Decreased sex drive	No	Yes
Pain during intercourse	No	Yes
Genital sores	No	Yes

Female :

Vaginal discharge	No	Yes
Vaginal dryness	No	Yes

Male:

Erectile dysfunction	No	Yes
- Difficulty obtaining erection	No	Yes
- Difficulty maintaining erection	No	Yes
Scrotal pain/mass	No	Yes
Penile discharge	No	Yes
Blood in semen	No	Yes
Curvature of penis	No	Yes

6. **Skin**

Do you currently have a rash?	No	Yes

7. **Neurological**

Tingling or numbness	No	Yes
Muscular weakness	No	Yes

8. **Musculoskeletal**

Bone Pain	No	Yes
Back Pain	No	Yes
Muscle Pain	No	Yes

9. **Endocrine**

Breast Enlargement	No	Yes
Always thirsty	No	Yes
Heat/cold Intolerance	No	Yes

10. **Psychiatric**

Anxiety	No	Yes
Difficulty sleeping	No	Yes

11. **Hematologic/Lymphatic**

Easy Bleeding	No	Yes
Bruise easily	No	Yes

12. **Allergic-Immunologic**

Allergy resulting in rash	No	Yes
Allergy causing difficulty breathing	No	Yes

Patient Name: ________________________________ **DOB:** ______________________

Signature: ____________________________________ **Date**: _____/______/_______

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Patient Medication List

Patient Name: ______________________________________ Date: _____/_____/_____

Local Preferred Pharmacy: ____

(Please include Prescription, Vitamins, and Over-the-counter Medications)

Medication	Dose	Time of Day (morning, noon, night)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Allergies

(Please list all known allergies, reactions and cause)

________ No Known Drug Allergies (X or initials)

1.
2.

3.
4.
5.

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FINANCIAL POLICY

Thank you for choosing Alaska Urology. We are committed to providing you the best urological healthcare available. You are required to read and sign our financial policy prior to any treatment. Please feel free to ask any questions and a copy of this policy will be provided to you upon request. As a courtesy to our patients, we bill all insurance types.

INSURANCE… We are participating providers for Medicare, Medicaid, Blue Cross/Blue Shield, Aetna, MultiPlan/BeechStreet and Cigna. It is **your responsibility** to know your insurance benefits. If you are unsure of your benefits, please contact your insurance carrier with questions. All patients with insurance coverage of any type must show their insurance card for us to bill your insurance. If you do not provide proof of insurance, you will be expected to **pay in full** at the time of service and will be considered a self-pay patient until the appropriate billing information is provided to our office. If you are not insured, **payment in full** is expected at the time service is rendered.

COPAYMENTS/COINSURANCE/DEDUCTIBLES… All patient responsibility for services must be paid at the time of service. This is part of your contractual obligation with your insurance company.

NON-COVERED SERVICES… Please be aware that some or all of the services provided may not be covered or not considered reasonable or necessary by some insurers. It is your responsibility to pay in full for these services at the time of your visit.

USUAL & CUSTOMARY… Our prices are representative of the usual and customary charges for our geographic area. You are expected to pay in full for any balance after insurance. At our discretion, Alaska Urology may assist you in appealing your insurance determination and/or appeal benefits on your behalf.

PROOF OF INSURANCE… All patients must complete our patient information forms and sign where indicated before being seen. We must obtain a copy of your insurance card(s) and a copy of a photo ID for billing. Failure to provide us with correct information will result in you being responsible for the balance of your claim.

CLAIMS SUBMISSION… As a courtesy to our patients, we will submit claims and assist you in a reasonable way to get your claims paid. Your insurance company may need you to supply certain information directly to them. It is **your responsibility** to comply with their request. Please understand and be aware that the balance of your unpaid claim(s) is your responsibility.

-------------------PLEASE SEE REVERSE SIDE-------------------

SURGERIES… All patient responsibility for surgeries must be paid in advance.

COVERAGE CHANGES… If your insurance changes, please notify us as soon as possible, so we can make the appropriate changes to help you receive your maximum benefits. **If your insurance does not pay your claim**, the balance may be billed to you.

NON-PAYMENT… If your account is thirty (30) days past due, you may be contacted by our billing department asking for payment in full. If your balance is unpaid after six (6) months, we may refer your account to our collection agency and you may be discharged from this practice.

PAYMENT OPTIONS… We accept Cash, Check, Money Order, Visa, MasterCard, and Discover. Please note there will be a $30 charge for checks returned for non-sufficient funds.

MISSED APPOINTMENTS… It is our policy to reserve the right to charge for missed appointments not cancelled with at minimum one (1) business day's notice of your scheduled appointment. Please assist us by keeping your appointment or cancelling with a minimum of one (1) business days notice. Appointments cancelled with less than one (1) business days notice will be considered a no-show. After one no-show, you will be required to pay a $25 deposit to schedule another appointment. If cancellation is not given in a minimum of (1) business day for the appointment, your $25 deposit will be forfeited and if you wish to reschedule, you will be asked for another $25 deposit. We reserve the right to discharge patients from our practice for chronic missed appointments.

PATIENT CONSENT/ASSIGNMENT… I hereby authorize Alaska Urology to release any information acquired in the course of my treatment to/from my insurance company, physician's office, hospital or any other treatment facility. I agree to be fully responsible for all expenses incurred for medical treatment. I assign to Alaska Urology any and all insurance benefits due to me, the full financial obligations for medical treatment that I have not paid for.

Our practice is committed to providing the best urological care to our patients. Thank you again for choosing Alaska Urology. Please let us know if you have any questions or concerns.

I have read and understand the Alaska Urology payment policy and agree to adhere to its guidelines.

I also hereby acknowledge that I have received Alaska Urology's Notice of Privacy Practices.

Patient Name: ____ DOB: ___________

Date: ___________________________

Signature: ____

Name: (if different than patient) _________________________________ DOB: ___________

Rev. 3/9/16