**Patient Registration:**

| | | | | | |
|---|---|---|---|---|---|
| **Name:** | | | | | |
| **Sex:** (circle one) | MALE FEMALE | **Date of Birth:** | MM/DD/YYYY | **SSN:** | - - |
| **Address:** | | | | | |
| | | | | | |
| **Employed:** | FULL TIME PART TIME UNEMPLOYED RETIRED (Circle One) | | | | |
| **Employer:** | NAME:<br>ADDRESS: | | | | |
| **Home Phone:** | ( ) - | **Work Phone:** | ( ) - | **Cell Phone:** | ( ) - |
| **Email Address:** | | | | | |
| **Primary Language:** (circle one) | **ENGLISH SPANISH OTHER:** | | | | |

**Race:**

| | | | |
|---|---|---|---|
| | White | | Black/African American |
| | Asian | | American Indian/Alaska Native |
| | Other | | Native Hawaiian/Other Pacific Islander |
| | Decline to Answer | | |

**Ethnicity:**

| | |
|---|---|
| | Spanish/Hispanic Origin |
| | Not of Spanish/Hispanic Origin |
| | Decline to Answer |

**Care Providers:**

| | | | | | |
|---|---|---|---|---|---|
| **Referring Provider:** | | **Address:** | | **Phone:** | |
| **Family Physician:** | | **Address:** | | **Phone:** | |

**Insurance Information:**

| | | | |
|---|---|---|---|
| **Primary Insurance Company & Policy Number:** | | **Coverage Under:** (Circle One) | PATIENT (SELF)<br>SPOUSE<br>PARENT/LEGAL GUARDIAN |
| **Secondary Insurance Company & Policy Number:** | | **Coverage Under:** (Circle One) | PATIENT (SELF)<br>SPOUSE<br>PARENT/LEGAL GUARDIAN |

**If patient is NOT the guarantor, please provide the following information:**

| | | | |
|---|---|---|---|
| **Guarantor Name:** | | | |
| **Date of Birth:** | MM/DD/YYYY | **SSN:** | - - |
| **Address:** | | | |
| **Employer:** | NAME:<br>ADDRESS: | | |

**HIPAA Acknowledgement**

I hereby acknowledge that I have received or had the opportunity to review a copy of Lancaster Urology's *Notice of Privacy Practices*, and I further authorize Urological Associates of Lancaster, Ltd. to release medical information to my insurance carrier, physician's office, any treating facility, or Power of Attorney.

Patient Signature Date

I further authorize Lancaster Urology to leave messages regarding **appointment information** on the following:

| | | | |
|---|---|---|---|
| | On home phone (including Auto Call) | | With Another Person (listed below) |
| | On cell phone (including Auto Call) | | Send via Mail |
| | On office voice mail | | Send via e-Mail |

I further authorize Lancaster Urology to leave messages regarding **medical information** on the following:

| | | | |
|---|---|---|---|
| | On home phone (including Auto Call) | | With Another Person (listed below) |
| | On cell phone (including Auto Call) | | Send via Mail |
| | On office voice mail | | Send via e-Mail |

Person (s) we are authorized to communicate with:

| | Name of Person | Relationship to Patient |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

Emergency Contact (s)

| | Name of Person | Phone Number | Relationship to Patient |
|---|---|---|---|
| 1. | | | |
| 2. | | | |

## Financial Policy

Lancaster Urology accepts insurance from most major insurance companies. All services provided are the patient's responsibility. As a courtesy, we will file claims with your insurance carriers provided we are supplied with your current insurance information. A copy of your insurance card and prescription card will be made at the time of your visit. If your insurance requires authorization from your primary care physician, you should present the authorization form at check-in. Failure to provide authorization will result in your appointment being rescheduled.

Insurance coverage is a contract between the patient and the insurance carrier. We participate with many insurance carriers and we will endeavor to assist you in filing your claim, and receiving payment from your insurance carrier. **In addition, we will collect co-payments, deductibles, and other out of pocket payment at the time of service.**

**Please contact your insurance carrier to verify your benefits as some preventive procedures and wellness visits are not covered.** All labs or x-rays should be verified with your carrier for the correct location, or your insurance may fail to pay. If your insurance requires pre-certification, please inform our staff so that we may assist you in this process. Failure to obtain pre-certification or authorization at the correct facility will result in the entire balance being the patient's responsibility.

**When you have a procedure performed by our physician, you will receive:**

1. A bill for our physician performing the service
2. If a tissue specimen is taken during your procedure, you will receive a separate bill for the pathology report
3. A separate bill from the facility if other than our office

All procedures are scheduled in advance. *If you must cancel a procedure or office visit, kindly give **24 hours notice*** so that another patient may be able to utilize your appointment. If you fail to notify us a, **$25.00 fee** will be charged. Continued cancelled appointments will result in additional fee assessed by our practice as well as feeds from ancillary services that cannot be cancelled.

Each month patients will receive a statement for services, which is due and payable within 30 days. If payment is late, or if the patient has not previously made financial arrangements, then the designated staff will mail a reminder notice, indicating there is a problem with the patient's account.

I acknowledge receipt of this policy.

_____ _____ _____

Printed Name Patient Signature Date

**MEDICAL HISTORY SHEET** **NAME:**_____

**PAST MEDICAL HISTORY** **DATE OF BIRTH:**_____

Check if you have ever been diagnosed with any of the following major medical problems:

**PULMONARY:**
☐ Asthma ☐ COPD ☐ Embolus

**ENDOCRINE:**
☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism

**CARDIAC:**
☐ Heart Attack ☐ Arrhythmia ☐ Mumur ☐ High Blood Pressure ☐ High Cholesterol

**GASTROINTESTINAL:**
☐ Ulcers ☐ GI Bleed ☐ Hepatitis ☐ Irritable Bowel ☐ Diverticulitis ☐ Reflux ☐ Crohn's

**NEUROLOGIC:**
☐ Stroke ☐ Parkinson's ☐ Depression ☐ Seizures ☐ MS ☐ Psychiatric Illness

**UROLOGIC:**
☐ Stones ☐ Kidney Cancer ☐ Bladder Cancer ☐ Testicular Cancer ☐ Prostate Cancer ☐ Incontinence ☐ ED

**OTHER:**
☐ STDs ☐ AIDS/HIV ☐ Fibromyalgia ☐ Bleeding Disorder ☐ Arthritis ☐ Glaucoma ☐ Anemia ☐ Phlebitis

**ADDITIONAL MEDICAL HISTORY:**

**SURGICAL HISTORY**

| Surgery Name | Date | Surgery Name | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**ANESTHESIA COMPLICATIONS:** _____

**HOSPITALIZATIONS**
**(exclude surgeries listed above)**

| Hospitalization Reason | Date | Hospitalization Reason | Date |
|---|---|---|---|
| | | | |
| | | | |

**FAMILY HISTORY**

| | | | |
|---|---|---|---|
| **Mother** | ALIVE DECEASED | **Major Medical Problems:** | |
| **Father** | ALIVE DECEASED | **Major Medical Problems:** | |
| **Other Family History:** | | | |

**SOCIAL HISTORY**

**Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed
**Tobacco Use:** ☐ Never ☐ Previous: ____#years ____#packs/day ☐ Current: _____years _____packs/day
**Alcohol Use:** ☐ Never ☐ Occasionally/Rarely ☐ Often - quantity:_____
**Occupation & Prior Occupation(if Retired):**_____

**CURRENT MEDICATIONS**

(include over-the-counter, medications, vitamins, herbal supplements- write additional on separate sheet of paper if necessary)

| Medication Name | Dose | When Taken | Medication Name | Dose | When Taken |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Allergies:**_____

**Preferred Pharmacy:**_____

*To the best of my knowledge, this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary service I may need.*

_____ _____

**Signature** **Date**