Arizona Urology Specialists
New Patient Registration Form

PLEASE PRINT

Last Name:_____ First Name: _____ MI: _____

Gender: Male / Female Date of Birth:_____ Age:_____

Race (i.e. Caucasian/Hispanic/Asian):_____Ethnicity (i.e. American/Mexican/German):_____

Primary Language:_____ Last 4 of Social Security #: _____

Address: _____City: _____Zip:_____

(H) Phone:_____ (C) Phone_____(W) Phone:_____

Preferred number to reach you? Home Cell Work OK to leave message at this number? Yes No

In case of emergency number:_____Contact name:_____

E-mail:

Preferred Appointment Reminder Method: Phone Mail E-mail

Primary Care Physician (PCP) / Family Doctor:_____ Phone:_____

Referring Physician:_____ Phone:_____

***Local Pharmacy Name:_____ Phone:_____**

Address or Cross-Streets:_____ **Phone:_____**

***Mail Order Pharmacy Name:_____**

Primary Insurance Name:_____

Primary Holder Name:_____ Date of Birth:_____

Secondary Insurance Name:_____

Primary Holder Name: _____ Date of Birth:_____

ASSIGNMENT OF BENEFITS

I hereby authorize my benefits to be paid directly to Arizona Urology Specialists, LLC and I am financially responsible for non-covered services and/or balances not paid by the insurance carrier. I also authorize release of my information required to process these claims. I authorize you to give me my medical care, including diagnosis and/or treatment.

_____ _____ _____

Signature of the Patient or the Patient's Legal Representative Date Relationship to Patient

Patient Name: _____ **DOB:** _____ **Date:** _____

Arizona Urology Specialists, LLC

Consents Form

Would you like a copy of the Notice of Privacy Practices? Declined ☐ Accepted ☐

Do you have an Advance Directive? (Legal document expressing your critical care wishes when you are unable to decide for yourself
Yes ☐ No ☐

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Arizona Urology Specialists, LLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Arizona Urology Specialists, LLC at any time to obtain a current copy.

**Signature:_____ Date:_____

Authorization of Release of Health Information:

I authorize the following individual(s) to have access to my personal health information.

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

**Signature:_____ Date:_____

Notice of Limited English Proficiency:

I have been offered a copy of the Notice of Limited English Proficiency. I understand that if I have Limited English Proficiency, I must provide a reliable, competent and proficient translator. If I cannot provide this translator, I must notify Arizona Urology Specialists, LLC in writing.

**Signature: _____ Date: _____

Consent to Obtain Electronic Medication History:

To optimize the use of electronic prescribing of medications and coordinate care between my providers, I hereby authorize Arizona Urology Specialists, LLC to access my medication history without limitation or exclusion as is reasonably necessary to disclose, retrieve, and view medications issued by a provider.

**Signature:_____ Date:_____

Portal Authorization:

The Patient Portal is a secure web-based system that allows for protected communication and transfer of information between the clinic and the patient. By signing below, you agree to the terms and conditions set forth in the Patient Portal Authorization Policy.

**Signature:_____ Date:_____

Patient Name: _____ **DOB:** _____ **Date:** _____

CHIEF COMPLAINT: Please provide the main reason for your visit today? (describe your problem in detail)

_____

_____

ALLERGIES: ☐ **NONE**

CIRCLE if you are allergic to the following?	LIST ALLERGIES TO MEDICATION AND REACTION:
Iodine	
Hibiclens	
Lidocaine/Marcaine	
Latex	

MEDICATIONS AND VITAMINS: ☐ **NONE**

NAME OF DRUG/SUPPLEMENT	STRENGTH OF DRUG (mg)	HOW OFTEN (# times per day)	NAME OF DRUG/SUPPLEMENT	STRENGTH OF DRUG (mg)	HOW OFTEN (# times per day)

Patient Name: _____ **DOB:** _____ **Date:** _____

MEDICAL HISTORY: List all illnesses, Example: (diabetes, tuberculosis, breast cancer, heart disease, etc.)

Do you have a history of Hypertension? YES NO Diabetes? YES NO

Have you ever received a pneumonia vaccine? YES NO

Medical Conditions	Year	Medical Conditions	Year

SURGICAL HISTORY: ☐ **NONE (Use the back of this form for additional space)**

	Procedure	Month/Year
1.		
2.		
3.		
4.		
5.		

FAMILY MEDICAL HISTORY:

FAMILY MEMBER	DETAILS	AGE	DISEASE(S)	IF DECEASED, CAUSE
Father				
Mother				
Sibling	□ M □ F			
Sibling	□ M □ F			
Sibling	□ M □ F			
Sibling	□ M □ F			

Any Relative diagnosed with **Kidney Cancer**? ☐ NO ☐ YES Relationship: _____

Any Relative diagnosed with **Bladder Cancer**? ☐ NO ☐ YES Relationship: _____

Any Relative diagnosed with **Prostate Cancer**? ☐ NO ☐ YES Relationship: _____

Patient Name: _____ **DOB:** _____ **Date:** _____

SOCIAL HISTORY:

1) Occupation: _____

2) Marital Status (please circle): Single Married Divorced Widowed

3) Do you have children/step-children? ☐ NO ☐ YES
   If yes, how many? _____ Age(s): _____

4) Do you exercise? ☐ NO ☐ YES

If yes, what type? How often? _____

TOBACCO / ALCOHOL / CAFFEINE:

1) Do you now or have you ever smoked? ☐ NO ☐ YES Year quit? _____
   If yes, what type? _____ How often? _____ How many? _____

2) Do you consume alcohol? ☐ NO ☐ YES
   If yes, what kind? _____ How often? _____ How much? _____

3) Do you consume caffeine? ☐ NO ☐ YES
   If yes, what kind? _____ How much? _____

4) Do you use illegal drugs? ☐ NO ☐ YES
   If yes, what kind? _____ How often? _____

Patient Name: _____DOB:_____ Date: _____

Do you have any of the following? Please mark an (X) in the spaces provided: Review of Symptoms

Constitutional Symptoms	**X**	**Genitourinary**	**X**	**Gastrointestinal**	**X**
Weight Change		Change in Stream		Abdominal pain	
Chills		Nocturia (getting up at night)		Nausea/vomiting	
Fever		Urinary frequency > 8times/day		Indigestion/heartburn	
Itching		Burning with urination		Constipation	
Night Sweats		Blood in urine		Diarrhea	
Other:		Trouble starting urine flow		**Other:**	
		Dribbling at end of urine flow			
		Urinary leakage			
		Other:			
Musculoskeletal	**X**	**EYES**	**X**	**Neurological**	**X**
Muscle weakness		Glaucoma		Tremors	
Joint pain (swelling)		Cataracts		Dizzy spells	
Sciatica		Wear glasses		Numbness/tingling	
Muscle pains		Blurred vision/Pain in your eyes		Stroke	
Muscle cramps stiffness		**Other:**		Seizures	
Other:				Insomnia	
				Other:	
ENT	**X**	**Cardiovascular**	**X**	**Respiratory**	**X**
Pain in ears		Chest pain		Wheezing	
Discharge from ears		Tightness/heaviness in chest		Frequent cough	
Motion sickness		Irregular heartbeat		Shortness of breath	
Difficulty hearing		Swelling in ankles		Are you on oxygen?	
Trouble with teeth		High blood pressure		**Other:**	
Trouble with gums		Shortness of breath			
Nose bleeds		Heart enlarged			
Other:		Low blood pressure			
		Feel palpitations			
		Feel skipped beats			
		Hear pound fast			
		Do you have a murmur?			
		Other:			
Endocrine	**X**	**Hematological/Lymphatic**	**X**	**Psychological**	**X**
Excessive thirst		Swollen glands		Do you feel depression?	
Too hot/cold		Blood clotting problems		Do you feel anxious?	
Other:		Bruising		Seeing a psychiatrist	
		Other:		Any psychiatric diagnosis?	
				Other:	
Sexual History	**X**		**X**	**(MEN ONLY)**	**X**
Change in sex drive?				Pain or swelling of testicles	
Sexual performance Satisfactory?				Discharge from penis	
Other:				Blood in Semen	
				Other:	

►►ALL PATIENTS PLEASE SIGN & DATE BELOW:

**Signature:_____ Date:_____