Urology Associates
of SENC, P.A.

UROLOGY ASSOCIATES OF SENC,PA **PROVIDER**_____

PATIENT INFORMATION: **CHART #**_____

Patient Name (Last, First, Middle)_____

Patient Mailing Address _____

City, State, Zip _____

Home Phone _____ Cell Phone _____ Other_____

Sex: Male ☐ Female ☐ Date of Birth_____ SS#_____

Martial Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Race: White ☐ Asian ☐ African-American ☐ Hispanic ☐

Ethnicity: Hispanic ☐ Latino ☐ NonHispanic or Latino ☐

Language: English ☐ French ☐ Spanish ☐

Employer _____ Phone _____

Person to Contact In Case Of Emergency (List Two)

Name _____ Phone(H)_____ (W)_____

Name _____ Phone(H)_____ (W)_____

If Patient is under 18 years of age:
Note: Guarantor must be the person who signs the consent for the patient to receive treatment today.

Please present your insurance card/cards to the receptionist.
If either insurance is not in the patient's name, we cannot file charges to the insurance without the following information

Guarantor Name _____ Relationship to Patient_____

Guarantor Address _____

Guarantor Phone _____ Guarantor SS #_____

DOCTOR INFORMATION:

Referring Doctor:_____ **Phone #** _____

Primary Care Doctor_____ **Phone #** _____

INSURANCE INFORMATION:

Insured's Name _____ **Insured's DOB**_____

Insured's Employer _____ **Insured's SS #**_____

Work Related Injury or Illness YES ☐ NO ☐ Date of Injury _____

EMAIL ADDRESS:_____

SIGNATURE _____ DATE _____

Urology Associates
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Please check the ☐ for all that apply for your appropriate health information:

Name_____ Today's Date_____

Date of Birth_____ Primary MD_____

Allergies:

☐ None ☐ IV Contrast ☐ Iodine ☐ Aspirin ☐ Codeine ☐ Demerol
☐ Penicillin ☐ SulfaJBactrim ☐ Cipro ☐ Macrobid ☐ Latex ☐ Morphine

Past Medical Illinesses:

☐ BPH ☐ None ☐ Low Testosterone ☐ Kidney Stones
☐ Kidney Cancer ☐ Prostate Cancer ☐ Recurrent UTI's ☐ Prostate Infections
☐ Urinary Incontinence ☐ Kidney Failure ☐ Heart Attack ☐ Heart Failure
☐ Diabetes ☐ Hypertension ☐ Stroke ☐ High Cholesterol
☐ Irregular Heart Beat ☐ Atrial Fibrillation
☐ Emphysema ☐ Asthma ☐ Anemia ☐ Migraines
☐ Depression ☐ Skin Cancer ☐ Hiatal Hernia ☐ Back Pain
☐ Sleep Apnea ☐ Stomach Ulcers ☐ Thyroid Disease ☐ HIV/Aids
☐ TB (Tuberculosis) ☐ Breast Cancer ☐ Reflux ☐ Colon Cancer
☐ Glaucoma ☐ Irritable Bowel ☐ Colon Polyps ☐ Seizures
☐ Gout ☐ Rheumatic Fever ☐ Other_____
☐ Sexually Transmitted Disease

Previous Surgeries: PLEASE INCLUDE DATE/YEAR

☐ Colon Resection_____ ☐ Groin Hernia_____ ☐ Joint Replacement_____
☐ Colonoscopy_____ ☐ Tonsils_____ ☐ Breast Removal for Breast
☐ Hiatal Hernia_____ ☐ Ovary_____ Cancer_____
☐ C-Section_____ ☐ Thyroid_____ ☐ Tubal Ligation_____
☐ TURP_____ ☐ Laser Prostate_____ ☐ Prostate Removal_____
☐ Heart Bypass_____ ☐ Kidney Stones_____ ☐ Uterus Removal_____
☐ Kidney Removal_____ ☐ Appendix_____ ☐ Gallbladder Removal____
Other_____

Social History:

Tobacco: ☐ I have never used tobacco products ☐ I use tobacco products

How many packs per day_____ ☐ I quit using tobacco procducts

Alcohol: ☐ Never ☐ Rarely ☐ Less than 2 days/week ☐ Daily ☐ I quit using alcohol

Family History: ☐ Prostate Cancer ☐ Kidney Cancer ☐ Kidney Stones ☐ Bladder Cancer

☐ I DOT NOT HAVE A FAMILY HISTORY OF URINARY CANCERS

Urology Associates
of SENC, PA

UROLOGY ASSOCIATES OF SENC, PA
Financial Policy

Thank You for choosing us as your health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. We expect full payment at time of service with the exception to this policy to include Medicare, Medicaid, United Healthcare,BCBS of NC and any other HMO's where we are legally obligated to file your claim for you. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

All patients must complete out patient information and Insurance forms and **pay all co-pays before seeing the doctor.** Please note per signed contracts with the managed care insurance companies we legally cannot bill you for your co-pay this is due to the provider at the time of treatment.

FULL PAYMENT IS DUE AT THE TIME OD SERVICE.
WE ACCEPT CASCH,CHECKS OR VISA/MASTERCARD, DISCOVER, AMERICAN EXPRESS AND DEBIT CARDS. IF YOUR INSURANCE REQUIRES AUTHORIZATION IT IS YOUR RESPONSIBILITY TO ENSURE THATYOU ARE AUTHORIZED ON THE DAY OF SERVICE. IN AN EFFORT TO MAINTAIN AVAILABLE APPOINTMENTS FOR PATIENTS CARE WE REQUEST THAT PATIENTS PROVIDE US WITH A 48 HOUR NOTICE TO CANCEL THEIR APPOINTMENT. A $30.00 FEE WILL BE APPLIED TO THEIR ACCOUNT IF THE PATIENT DOES NOT COMPLY.

Regarding Indemnity Insurance
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We cannot bill your insurance company unless you give your insurance information. If you insurance company has not paid your account in full in 45 days, the balance is your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and / or other medical insurance.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients
The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment by cash, check or credit card at the time of services has been verified.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this financial policy:

X _____ Date:_____
Signature of Patient or Responsible Party

Urology Associates of SENC, P.A.

Name____**Date of Birth** ________________

PHARMACY NAME AND LOCATION:

____

Medication Name: Example - Aspirin	**Dosage:** 81 mg	**Number of times taken per day:** Daily

Urology Associates of SENC, P.A.

UROLOGY ASSOCIATES OF SOUTHEASTERN NORTH CAROLINA, PA
1905 GLEN MEADE ROAD
WILMINGTON, NC 28403
Phone 910-763-6251 Fax 910-763-7408

Patient Name_____ Chart# _____

Date of Birth _____ PHONE _____

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (HIPPA)

Health information records that may be used/disclosed/released (initial all that apply):

_____ All Records

_____ Only Records Dated from _____ to _____

Specify if these records are to be used/disclosed/released:

Mental health _____Substance use disorder treatment of HIV/Aids _____Other _____

Persons that may use/receive information:

_____ _____

_____ _____

Expiration: This authorization is effective for 1 year after the date of signature

RELEASE OF MEDICAL RECORDS

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED:

From: Name of Practice _____

Address: _____

_____

Phone: _____ Fax: _____

To: Name of Practice _____

Address: _____

_____

Phone: _____ Fax: _____

Signature of Patient _____ Date _____

Printed Name _____ Relation to Patient _____

If signed by someone other than patient, please indicate relationship (e.g. parent, POA, etc)

Urology Associates

PLEASE CIRCLE YES OR NO FOR ALL THAT APPLY

PATIENT NAME _____

Review of Systems	Yes	No
General:		
Weight Gain	○	○
Weight Loss	○	○
Appetitle Loss	○	○
Chills	○	○
Fever	○	○
Weight Loss > 10lbs	○	○
Skin:		
Dryness	○	○
Hives	○	○
Itching	○	○
Rash	○	○
HEENT:		
Blurred Vision	○	○
Headache	○	○
Eye Pain	○	○
Visual Loss	○	○
Hearing Loss	○	○
Ear Pain	○	○
Nose Bleed	○	○
Sinus Pain	○	○
Sore Throat	○	○
Voice Changes	○	○
Respiratory:		
Cough	○	○
Decreased Exercise Tolerance	○	○
Difficulty Breathing	○	○
Shortness of breath	○	○
Wheezing	○	○
Breast:		
Breast Mass	○	○
Breast Pain	○	○
Breast Swelling	○	○
Nipple Discharge	○	○
Nipple Pain	○	○
Skin Changes	○	○

Review of Systems	Yes	No
Cardiovascular:		
Chest Pain	○	○
Edema	○	○
Palpitations	○	○
Shortness of Breath	○	○
Swelling of Legs	○	○
Gastrointestinal:		
Hemorrhoids	○	○
Abdominal Pain	○	○
Change in Bowel Habits	○	○
Indigestion	○	○
Nausea	○	○
Vomiting	○	○
Genitourinary:		
Change in Urinary Stream	○	○
Burning when you urinate	○	○
Frequency	○	○
Blood in the urine	○	○
Incontinence	○	○
Urgency	○	○
Impotence (Men)	○	○
Nighttime urinating	○	○
Musculoskeletal:		
Bone pain	○	○
Neurological:		
Trouble walking	○	○
Headaches	○	○
Seizures	○	○
Psychiatric:		
Anxiety	○	○
Depression	○	○
Endocrine:		
Sexual Dysfunction	○	○
Hematology:		
Easy Brusing	○	○