Urology Associates of SENC, P.A.

Patient Information

Patient Name:	Last:		First:		Middle:
Patient Address:	Street:				Apt/Bldg/Lot:
City:		State:		Zip:	
Email Address:					
Phone:	Cell:		Home:		Other:
Sex:	☐ Male	☐ Female	Date of Birth:		SSN:
Marital Status:	☐ Single	☐ Widowed	Race:		Pref. Language:
	☐ Married	☐ Divorced	Ethnicity:		

Employer:		Phone:	
Please List Two: Emergency Contact:		Phone:	
Emergency Contact:		Phone:	
Guarantor must be listed if the patient is under 18 years of age. The guarantor must be the person who signs the consent for the patient to receive treatment today.			
Guarantor Name:		Relationship to Patient:	
Guarantor Address:			
Guarantor Phone:		Guarantor SSN:	

Please present your insurance card/cards to the front desk. If either insurance is not in the patient's name, we can not file charges without the following information.					
Insured Name:		Insured DOB:		Insured SSN:	
Primary Insurance:		Policy #:		Group #:	
Secondary Insurance:		Policy #:		Group #:	

Referring Doctor:		Phone #:	
Primary Care Doctor:		Phone #:	

Patient DOB:		Today's Date:	
Patient Name: (Please Print)			

Allergies: Please indicate all allergies and list any not named:			Other:		
☐ None	☐ IV Contrast	☐ Iodine	☐ Aspirin	☐ Codeine	☐ Demerol
☐ Penicillin	☐ Sulfa	☐ Cipro	☐ Macrobid	☐ Latex	☐ Morphine

Medical History: Past Medical Illnesses. Please list any not named:			*Other:*			
☐ Acid Reflux	☐ Breast Cancer	☐ Glaucoma	☐ HIV/Aids	☐ Kidney Stones	☐ Rheumatic Fever	☐ Stroke
☐ Anemia	☐ Colon Cancer	☐ Gout	☐ Hypertension	☐ Low Testosterone	☐ Seizures	☐ TB (Tuberculosis)
☐ Asthma	☐ Colon Polyps	☐ Heart Attack	☐ Irregular Heartbeat	☐ Migraines	☐ Sexually Transmitted Disease	☐ Thyroid Disease
☐ Atrial Fibrillation	☐ Depression	☐ Heart Failure	☐ Irritable Bowel	☐ Prostate Cancer	☐ Sleep Apnea	☐ Urinary Incontinence
☐ Back Pain	☐ Diabetes	☐ Hiatal Hernia	☐ Kidney Cancer	☐ Prostate Infections	☐ Skin Cancer	☐ None
☐ BPH	☐ Emphysema	☐ High Cholesterol	☐ Kidney Failure	☐ Recurrent UTIs	☐ Stomach Ulcers	

Surgical History: Please list all surgeries, including the year	

Social History:	Tobacco Use:	☐ Current User	☐ Former User	If yes, year quit:	☐ Never Used
Type:		Amount per day:		# of years used:	

Alcohol Use:	☐ Current User	☐ Former User	☐ Never Used	If current, Type:
				How much per day/week:

Drug Use/Substance Abuse:	☐ Current User	☐ Former User	☐ Never Used	If current, please list:

Family History:	☐ Prostate Cancer	☐ Kidney Cancer	☐ Bladder Cancer	☐ Kidney Stones	☐ No history of urinary cancers	Other:

Health Maintenance: Please provide the most recent dates.	Colonoscopy Date:	Flu Vaccine Date:	Pneumonia Vaccine Date:	Covid Vaccine(s) Date:

Medication List:	Mail Order Pharmacy:
Local Pharmacy Name and Location:	

Please indicate medication name, strength, and times per day (i.e. Aspirin, 81mg, Once Daily). If you need more space please write on other side of page:	

Patient DOB:		Today's Date:	
Patient Name: (Please Print)			

Review of Systems					
Please Check Yes or No					
General:	Yes	No	Cardiovascular:	Yes	No
Weight Gain			Chest Pain		
Weight Loss			Edema		
Weight Loss > 10 lbs			Palpitations		
Appetite Loss			Swelling of Legs		
Chills			Gastrointestinal:		
Fever			Hemorrhoids		
Skin:			Abdominal Pain		
Dryness			Change in Bowel Habits		
Hives			Indigestion		
Itching			Nausea		
Rash			Vomiting		
HEENT:			Genitourinary:		
Blurred Vision			Change in Urinary Stream		
Headache			Burning during Urination		
Eye Pain			Frequency		
Vision Loss			Blood in Urine		
Hearing Loss			Incontinence		
Ear Pain			Urgency		
Nose Bleed			Impotence (Men)		
Sinus Pain			Nighttime Urinating		
Sore Throat			Kidney Pain		
Change in Voice			Musculoskeletal:		
Respiratory:			Bone Pain		
Cough			Neurological:		
Decreased Exercise Tolerance			Trouble Walking		
Trouble Breathing			Headaches		
Wheezing			Seizures		
Shortness of Breath			Psychiatric:		
Breast:			Anxiety		
Breast Mass			Depression		
Breast Pain			Endocrine:		
Breast Swelling			Sexual Dysfunction		
Nipple Discharge			Hematology:		
Skin Changes			Easy Bruising		

Payment Policy

Thank you for choosing Urology Associates of SENC, PA as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Please be sure to carefully read our payment policy. A copy can be provided upon request.

- **Insurance:** We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance requires an authorization, it is your responsibility to ensure that you are authorized on the day of service.
- **Co-payments and deductibles:** This arrangement is part of your contract with your insurance company. Co-pays and deductibles must be paid before seeing the practitioner. If your insurance company has not paid your account in full in 45 days, the balance is your responsibility.
- **Non-covered services:** Please be aware that some of the services you receive may be non-covered or not considered reasonable and necessary by Medicare or other insurers. You must pay for these services in full at the time of service.
- **Proof of Insurance:** All patients must complete a patient information form before seeing the practitioner. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- **Claims submission:** We will submit your claims and assist you in any way we can to help get your claims paid. Please be aware that any unpaid balances are your responsibility.
- **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefit.
- **Minor Patients:** The adult accompanying a minor and the parent (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment at the time of service has been verified.

Consent to Medical Treatment

I have reviewed and consent to the following:

- I voluntarily present for treatment and consent to my provider to provide my care. Such care may include, but is not limited to, diagnostics procedures, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.
- I acknowledge that my treatment is intended to address specific illnesses and is not intended as a substitute for a primary care physician and that no guarantee can be made or has been made as to the result of treatments or examinations at Urology Associates of SENC, PA.
- In the event an employee has a needle stick or otherwise is exposed to my blood or body fluids, I consent to testing for HIV or Hepatitis C & B.

By signing below, I acknowledge that I have reviewed Urology Associates of SENC, PA's payment policy and consent to medical treatment.

Print name of person signing: _____ Relationship to Patient: _____

_____ _____

Signature of patient (or guardian) Date

Patient DOB:		Today's Date:	
Patient Name: (Please Print)			

HIPAA Authorization

I authorize the use and/or disclosure of my protected health information, as set forth below. I understand that this authorization is voluntary. I understand that, if the persons or organizations I authorize below are not healthcare providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

This authorization will remain in place until a notice of change is provided in writing.

Protected Health Information to Be Used and/or Disclosed:

- I authorize Urology Associates of SENC, PA to discuss medical information regarding my care, test results, appointments and /or billing information with someone other than myself. **Yes** ☐ **No** ☐
- If yes, I authorize Urology Associates of SENC, PA to disclose my protected health information to the following individuals, who may be contacted directly by Urology Associates of SENC, PA.

Name	Relationship	Phone Number

- I authorize Urology Associates of SENC, PA to leave a message regarding my medical care on my voicemail. **Yes** ☐ **No** ☐
- I authorize Urology Associates of SENC, PA to send appointment reminders via Text Message. **Yes** ☐ **No** ☐

If yes, please provide the phone number: _____

**Please note data charges may apply per your cell phone carrier*

I acknowledge that I have been made aware of Urology Associates of SENC, PA's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of the Urology Associates of SENC, PA's Notice of Privacy Practices.

_____ _____

Signature Date

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:	
Relationship to Patient:	

Urology Associates of SENC, P.A.

Medical Release Authorization

Request for Healthcare Information

Please forward the healthcare records for the following patient:
Fax to (910) 763-7408 or mail to 1905 Glen Meade Road, Wilmington, NC 28403

Authorization to Obtain Protected Health Information

Patient Name:	Last:	First:	Middle:
Date of Birth:		Phone:	

☐ I authorize Urology Associates of SENC, PA to obtain and the named facilities to release to Urology Associates of SENC, PA my health care information.

From: _____

Address: _____

_____

Phone: _____ Fax: _____

This release applies to:

☐ My complete medical record
☐ My medical records for the dates ____/____/____ to ____/____/____
☐ Lab Test
☐ Diagnostic Imaging Reports
☐ Operative Notes
☐ Office Visit Notes
☐ Other: _____

☐ I prefer that my records be sent in the following manner:

☐ Mail to Address: _____

☐ Phone: _____

☐ Fax: _____ Attention: _____

☐ Email: _____

☐ Hold for Pickup

Patient Signature: (or Guardian)		Date:	
Printed Name of Person Signing:		Relationship to Patient:	