METROWEST UROLOGY, PC

www.mwurology.com

PATIENT INFORMATION (Please print information clearly)

Last Name	First	MI	Dr ☐ Mr. ☐ Ms ☐ Mrs. ☐ Miss ☐
Date of Birth / Age / Race / Male ☐ Female ☐	Social Security #	Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐	
Street Address	City / State	Zip Code	Day Phone Evening Cell Phone
Email Address	May we leave a message on the answering machine/voicemail? Yes☐ No☐		
Patient's Occupation	Employer		Employer Phone
Spouse's Last Name	First	MI	Dr ☐ Mr. ☐ Ms ☐ Mrs. ☐ Miss ☐
Spouse's Occupation	Employer		Employer Phone
Driver's License #	State	Have your other family members been seen at MetroWest Urology?	

How did you hear about us? Insurance Plan Friend Internet/Web Page Yellow Pages Other

PRIMARY CARE PHYSICIAN

Last Name	First	Specialty Office Phone

REFERRING PHYSICIAN

Please complete if Referring Physician is not your Primary Care Physician

Last Name	First	Office Phone

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone	Work Phone

PHARMACY

Pharmacy Name	Location	Phone Number Fax Number

PLEASE LIST ANY MEDICATION ALLERGIES

INSURANCE INFORMATION

Please present your insurance card(s) with your registration form. We will copy all the information necessary for benefit reimbursement purposes.

Co-payments are due at time or service. Please note, with some insurance providers, MetroWest Urology may be considered a specialty referral and your co-payment may be higher than reflected on you insurance card. Please check with your HealthCare provider if you have any questions. We appreciate the opportunity to serve you at MetroWest Urology. Thank you for your patronage.

THE FOLLOWING INFORMATION IS FOR OFFICE USE ONLY. PLEASE DO NOT COMPLETE UNLESS WE REQUEST IT AT TIME OF REGISTRATION. THANK YOU!

Primary Insurance	**Policy #**		**Group #**
Subscriber's Name	**SSI #**	**DOB**	**Relationship to Patient** **Self ☐ Spouse ☐ Child ☐ Other ☐**
Secondary Insurance	**Policy #**		**Group #**
Subscriber's Name	**SSI #**	**DOB**	**Relationship to Patient** **Self ☐ Spouse ☐ Child ☐ Other ☐**
Co-payment amount	**Referrals Needed** **Yes No**	**Pre-certifications Needed** **Yes No**	**Other**

Notes:

METROWEST UROLOGY, PC

www.mwurology.com

Patient's Certification and Authorization for Insurance Reimbursement and Agreement for Payment	
The attached information is true to the best of my knowledge. I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to MetroWest Urology, PC for medical services rendered to myself and/or my dependents regardless of insurance benefits, if any. I also authorize MetroWest Urology, PC or insurance company to release any information required to process my claims, secure payment or for treatment and healthcare operations. I have requested medical services from MetroWest Urology, PC on behalf of myself and/or dependents and understand by making such request that I become fully financially responsible for any and all charges incurred for the course of treatment authorized. I understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I understand that I am financially responsible for any balance. I further understand that it is my responsibility to secure referrals and all necessary authorizations under the guidelines of my insurance policy. I acknowledge that I will be financially responsible for all charges incurred should I not follow the terms and provisions of my health insurance policy. In the event of default, I understand that MetroWest Urology, PC may use an outside collection agency and/or report any returned checks to the Attorney General's Office for the Commonwealth of Massachusetts. Not only will a photocopy of this assignment be considered as valid as the original but will also be valid for the period of lifetime unless revoked by me in writing.	
Patient/Legal Guardian/Authorized Person (Signature) X	**Date of Signature** X
Patient/Legal Guardian/Authorized Person (Please Print Name)	**Relationship If Other Than Patient**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

I acknowledge that I have received and reviewed the Notice of Privacy Practices and Patients' Rights pertaining to this office and its affiliated covered entities, and all my questions have been answered to my satisfaction. Also, I consent to the use or disclosure of my protected health information by MetroWest Urology PC, and all of its departments, operations, and locations for the purpose of diagnosing or providing treatment, obtaining payment for my healthcare services, or to conduct its healthcare operations that specifically includes all satellite locations, billing and administration, laboratory and diagnostic center.

X____ X ____________________________

Patient/Legal Guardian/Authorized Person (Signature) **Date of Signature**

____ ____________________________

Patient/Legal Guardian/Authorized Person (Printed Name) **Relationship if other than Patient**

AUTHORIZATION ALLOWING DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE FOLLOWING INDIVIDUALS LISTED BELOW

In compliance with HIPAA's Privacy Rule, it is the policy of MetroWest Urology, PC to allow properly authorized individuals to have access to your protected health information (PHI). This authorization will remain in force until revoked in writing by the Patient. Please list below the individuals you wish to have access to your protected health information.

1 ____ ____________________________

Name **Relationship**

2 ____ ____________________________

Name **Relationship**

X____ X ____________________________

Patient/Legal Guardian/Authorized Person (Signature) **Date of Signature**

____ ____________________________

Patient/Legal Guardian/Authorized Person (Printed Name) Relationship if other than Patient

METROWEST UROLOGY, PC

www.mwurology.com

HEALTH HISTORY QUESTIONNAIRE

DATE _______/_______/_______

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	M F	DOB____/____/____
Height:	Weight:	Referring Physician:

PRESENT UROLOGIC HEALTH CONCERN(S)

Please describe your current urologic problem(s) and why you are seeking consultation.

ILLNESSES (Please check all that apply)

Have you ever been diagnosed with any of the following illnesses or medical problems? If yes, please include approximate date or year.

Illness	Date/Yr	Illness	Date/Yr
High Blood Pressure	Date/Yr:	Asthma/Bronchitis	Date/Yr:
Coronary Artery Disease	Date/Yr:	Emphysema	Date/Yr:
Heart Attack	Date/Yr:	Multiple Sclerosis	Date/Yr:
Angina	Date/Yr:	Parkinson's Disease	Date/Yr:
Heart Failure	Date/Yr:	Alzheimer's Disease	Date/Yr:
Mitral Valve Prolapse	Date/Yr:	COPD	Date/Yr:
Cerebrovascular Accident (Stroke)	Date/Yr:	Seizures	Date/Yr:
Diverticulosis/Diverticulitis	Date/Yr:	Thyroid Disease	Date/Yr:
Gout	Date/Yr:	Diabetes	Date/Yr:
CHF	Date/Yr:	Hiatal Hernia	Date/Yr:
Cardiac Arrhythmia	Date/Yr:	Glaucoma	Date/Yr:
Heart Murmur	Date/Yr:	HIV/AIDS	Date/Yr:
Abdominal Aortic Aneurysm	Date/Yr:	Transient Ischemic Attack	Date/Yr:
Pulmonary Tuberculosis	Date/Yr:	Deep Venous Thrombosis	Date/Yr:
Genital Condyloma	Date/Yr:	Genital Herpes	Date/Yr:
Padget's Disease	Date/Yr:	Hepatitis	Date/Yr:
Anemia	Date/Yr:	Cholelithiasis	Date/Yr:
Leukemia	Date/Yr:	Ulcerative Colitis	Date/Yr:
Cervical Cancer	Date/Yr:	Osteoarthritis	Date/Yr:
Ovarian Cancer	Date/Yr:	Colon Cancer	Date/Yr:
Breast Cancer	Date/Yr:	Cystocele/Rectocele	Date/Yr:
Bladder Cancer	Date/Yr:	Hodgkin's Disease	Date/Yr:
Prostate Cancer	Date/Yr:	Malignant Lymphoma	Date/Yr:
Testis Cancer	Date/Yr:	Lung Cancer	Date/Yr:
Kidney Stones	Date/Yr:	Kidney Cancer	Date/Yr:
Urinary Incontinence	Date/Yr:	Penile Cancer	Date/Yr:
Prostate Enlargement (BPH)	Date/Yr:	Erectile Dysfunction (ED)	Date/Yr:
Prostatitis	Date/Yr:	Urinary Tract Infection	Date/Yr:

Physicians Use Only – (Notes/Comments)

OPERATIONS		
Please list all surgeries including approximate date or year.		
Surgery	Diagnosis	Date/Year

MEDICATIONS			
Please list your prescribed drugs and over-the-counter drugs, such as vitamins and nutritional supplements including approximate start date.			
Name of Drug	Strength	Frequency Taken	Start Date/Year

ALLERGIES	
Please list all drug allergies including type of reaction.	
Name of Drug	Reaction

FAMILY HEALTH HISTORY	
No History of Familial Disease	
Relative (i.e. Father, Mother, Uncle, Sister, etc.)	Illness (i.e. Diabetes, Heart Disease, Prostate Cancer, etc.)

PERSONAL HISTORY AND HEALTH HABITS			
Marital Status	Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐		
Religion			
Occupation			
Physical Activity	Non-Ambulatory Limited-Mobility Inactive	Walking Running Aerobic Training	Strength Training Swimming Recreational Activities

Dietary	Regular Low Fat Vegetarian Diabetic	Renal Failure Gluten Free Weight Reduction	Weight Gain Lactose Free Other
Advance Directive	None	Living Will	Surrogate
Alcohol Use	None		
	Drinks/weekly	Duration in years	Date Discontinued
Tobacco Use	None		
	Cigarette (pks/day)	Duration in years	Date Discontinued
	Other (#/day)	Duration in years	Date Discontinued
Drug Use	None		
	Marijuana (#/day)	Duration in years	Date Discontinued
	Cocaine (#/day)	Duration in years	Date Discontinued
	Other (#/day)	Duration in years	Date Discontinued

Physicians Use Only – (Notes/Comments)

REVIEW OF SYSTEMS (Please check all that apply)			
General	Anorexia Fever Weight Loss/Gain	Sweats Chills Headache	Malaise Fatigue
Eyes	Double Vision Vision Loss	Eye Pain Eye Irritation	Eye Discharge Blurred Vision
Ears, Nose and Throat	Decreased Hearing Hoarseness Ear Infection	Ringing in Ears Ear pain Sore Throat	Nose Bleeds Pain with Swallowing Sinus problems
Cardiovascular	Chest Pain Chest Pressure	Rapid heartbeat Irregular heartbeat	Peripheral Edema Pacemaker
Respiratory	Frequent Cough Shortness of Breath	Wheezing Asthma	Bloody Sputum
Gastrointestinal	Abdominal Pain Diarrhea Bloody Stools	Nausea Constipation Vomiting	Tarry Stools Indigestion Heartburn
Musculoskeletal	Back Pain Muscle Weakness	Joint Pain Joint Swelling	Neck Pain
Skin	Dryness Suspicious Lesion	Persistent Itching Rash	Boils/Cysts Sores that don’t heal
Neurological	Dizziness Seizures	Weakness Numbness	Tremors
Psychiatric	Depression Hallucinations	Anxiety	Memory Loss

Endocrine	Cold/Heat Intolerance Weight Change	Hair Loss	Increased Thirst
Hematological and Lymphatic	Abnormal Bruising	Easy Bleeding	Enlarged Lymph Nodes
Allergic and Immunologic	Hay Fever	Itching	HIV Exposure
Genitourinary	Blood in Urine Bladder/Urinary Infection Difficulty Voiding Flank Pain Frequent Urination Hesitancy	Incomplete Voiding Infertility Kidney Stones Kidney Infection Lack of Control Leaking of urine	Painful Urination Sexual Dysfunction Slow Stream Urgency Urinating at Night

Men	Penis Discharge Prostate Infection Penis Sores	Abnormal lumps in scrotum Erection Difficulties Fertility problems
Women	Abnormal Pap Smear Vaginal Infections Breast Lump Hot Flashes Nipple Discharge	Painful Intercourse Vaginal Discharge PMS Menstrual/Painful Periods

OB/GYN	Could you be pregnant? Yes No Date of last period ______/______/______ Is your menstrual cycle: (Please check one) Normal Irregular Heavy Light How many children have you had?_________ Number of C-Sections ____________ Number of Vaginal Deliveries _______Number of terminations/miscarriages______ Were there any complications? Please explain: ______________________________ ____ Date of last mammogram______/______/______

Physicians Use Only – (Notes/Comments)

CERTIFICATION	
The above information is true to the best of my knowledge.	
Patient/Legal Guardian/Authorized Person (Signature) X	Date
Patient/Legal Guardian/Authorized Person (Please Print Name)	Relationship If Other Than Patient

MD Signature_______________________________________ Date Reviewed:___________________