Urological Associates of Central Jersey, P.A. Today's date:__________________

2177 Oak Tree Road, Suite 210, Edison, NJ 08820
Phone: 908-754-2100 Fax: 908-756-0027

Patient Name: (Last)____________________________ (First)______________________________(MI)_____________

Sex: □ M □ F Birthdate (mm/dd/yyyy): _________________________Age:__________________

Mobile Phone: ________________________________ Email address: ____

Home Phone: ____________________________________ Social Security #:_____________________________________

Patient Address: ____

City: __________________________________State: ___________________ Zip: _________________________

Marital Status: □S □W □M □D

Preferred Method of Communication:

□ Email □Mobile phone □ Home Phone □Mail □Work Phone □ Pt declined to specify

May we leave voice messages for you? □ Yes □ No What Phone #? _______________________

Insurance Information: (please list name of insurance holder if other than self)

Primary Insurance Company: ____

Name of Insured: _____________________Relationship to patient: ____________________DOB:______________

Secondary Insurance Company: ____

Name of Insured: _____________________Relationship to patient: ____________________DOB:______________

Additional Health Insurance: ____

Do you authorize this practice to retrieve your prescription history? □ Yes □ No

Please circle Patient's Race: African American, Asian, American Indian, Alaskan Native, Native Hawaiian, Caucasian, Pacific Islander, Unknown Other:______________________

Please circle Patient's Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, Unknown
Preferred Language:____

Spouse/Guardian Information:

Name: ____ Relationship: _________________ DOB:____________

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In Case of Emergency who should we contact?:

Name: ______________________________ Relationship: ______________________ Phone:_______________

SOCIAL HISTORY:

Tobacco Use: □ Never Smoked □Current □ Former Smoker □ Unknown if ever smoked

Smoker Status: □ Current □ Every Day Smoker □ Social Smoker

Have you tried to quit? □ N □ Y Year: _______

Caffeine: □ N □ Y Type: ____________________________ Amount of caffeine per day ___________

Alcohol: □ N □Y Type: __________________ Frequency: __________ Amount: ______

Drug Use**:** □ N □ Y

Do you have an Advance Directive? □ Yes □ No

Please circle ALLERGIES: None Codeine IVP Dye Latex Mycins Penicillin Sulfa Drugs

List any other ALLERGIES (meds, food, or environment): ____

MEDICAL HISTORY: (Please check if you have had any of the following):

□ Asthma □ Diabetes □ High Blood Pressure □ Prostate Cancer
□ Cancer □ Heart Attack □ Kidney Failure □ Urinary/Bladder Infections
□ COPD □ Heart Disease □ Kidney Stones □ Stroke / TIA
□Other Medical Problems/Conditions: ____

SURGICAL HISTORY: (Please check if you have had any of the following and when):

□ Appendix ________ □ Gallbladder ________ □ Heart Stents________ □ Other: ________________
□ C- Section ________ □ Heart Angioplasty________ □ Hernia________ □ Other: ________________
□ Colon surgery________ □ Heart Bypass________ □ Hysterectomy________ □ Other: _________________

FAMILY HISTORY: Check diseases known in your blood relatives (not yourself)

□ Bladder Cancer Relation: _____________ □ Kidney Disease Relation: _____________
□ Diabetes Relation: _____________ □ Kidney Stones Relation: _____________
□ Heart Disease Relation: _____________ □ Other Cancer Relation: _____________
□ Prostate Cancer Relation: _____________ what type? ______________________________

Do you now have or have had any of the following?

□ Bladder Disease □ Dribbling urine □ High blood pressure □ Painful Urination
□ Blood in urine □ Heart Trouble □ Kidney Disease □ Palpitations
□ Chronic UTIs □ Heart Disease □ Kidney Stones

FEMALES ONLY: Date of last Menstrual Cycle**?** ___________ Menopause? □ If so when? ________

IMMUNIZATIONS

Tetanus Y N (date) ___________ Influenza Y N (date) __________ Pneumonia Y N (date) ___________

Please list the names of any person(s) we may speak to regarding your medical status:

Name:____ Relation:______________________________

Name:____ Relation:______________________________

Name:____ Relation:______________________________

WE WILL NOT BE ABLE TO RELEASE MEDICAL INFORMATION REGARDING YOUR CARE WITH PERSONS NOT LISTED ABOVE.

Who may we thank for referring you to us?____

Who is your Primary Care Physician?:____

Reason for Today's Visit: ____

____

Have you had any recent X-rays or Scans? □ Yes □ No

Please explain what test/procedure was done: ____

____

Preferred Pharmacy: ____ Phone #: ____________________

Pharmacy Address: ____

Name of Medication	Strength (mg)	How do you take it (Frequency)

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PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my Protected Health Information (PHI) to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third-party payers (eg. Insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of the *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my PHI, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice and that I may contact the office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my PHI is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

Print Patient Name: ________________________________ **Date**:__________

Signature of Patient:____

Signature of Patient Representative:___________________________________
(Required only if patient is a minor or an adult unable to sign this form)

Relationship to Patient:____

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PRIOR AUTHORIZATION POLICY

EFFECTIVE FEBRUARY 20, 2017

PRIOR AUTHORIZATIONS FOR CT SCANS AND MRI'S:

Our staff will make every effort to conduct a "prior authorization" on your behalf so that you can schedule your radiology test.

Our office will obtain from you the name of the facility and the location where you will be having your radiology testing done. This information is provided to your insurance company during the prior authorization process.

Please note that if you change the testing facility and/or location after the prior authorization has been completed, there will be a fee of $25.00 for our office to arrange for a revision to the prior authorization.

PLEASE DO NOT SCHEDULE YOUR APPOINTMENT WITHOUT AN AUTHORIZATION NUMBER.

This prior authorization process may take a few weeks. We will contact you as soon as we receive notification.

PRIOR AUTHORIZATIONS FOR MEDICATIONS (for males)

In our experience and due to changes in the prior authorization guidelines for 2017, insurance companies have not been approving prior authorizations for the following medications:

- **Sildenafil - we can provide the name of a pharmacy that offers Sildenafil at a discounted rate.**
- **Cialis 20mg**

Due to the amount of time that is involved with the prior authorization process, there will be **a fee of $25.00** for our office to process a prior authorization for the above medications. (THIS DOES NOT APPLY TO TRADITIONAL MEDICARE PATIENTS).

______________________________ ______________________
Patient's Signature Date

____
Print Name