SAN JUAN UROLOGY ASSOCIATES P.C.

904 SOUTH 4TH STREET

MONTROSE, CO 81401

970-249-2291

Patient Information

Appointment Day and Time: _____

Name: _____ Sex: M / F E-MAIL ADDRESS _____

Social Security: _____ Date of Birth: _____ Marital Status: M / S / D / W

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Phone Numbers:

Primary: _____ (H /W/ C)

Secondary: _____ (H / W/ C)

Alternate: _____ (H / W / C)

Employer:

Company: _____

Status: (circle one): Full-time Part-time

Retired: Y / N Unemployed: Y / N

Additional Information

Preferred Language _____ Pharmacy: _____

Ethnicity: (check one) Hispanic or Latino _____ or Non Hispanic or Latino _____

Race: (check one) White _____ Black or African American _____ American Indian or Alaska Native _____ Asian _____

Native Hawaiian or Other Pacific Islander _____ Multiracial _____

Referring Physician: _____ Primary Care Physician: _____

Emergency Contact: _____ Relationship _____ Phone #: _____

Insured Information

Insurance Company: _____ Effective Date: _____

Insurance Policy #: _____ Group Number: _____

Insurance Claims Address: _____

Primary Insured Name: _____ Insured Relationship to patient: _____

Insured Phone: _____ Insured SS # : _____ Insured Date of Birth: _____

Secondary Insurance CO: _____ Effective Date: _____

Insurance Policy #: _____ Group #: _____

Responsible Party if patient is a minor: _____

Responsible Party Address: _____

Insurance authorization and assignment

I hereby authorize San Juan Urology to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance, and all collection costs should this account be assigned for collection. I accept and understand the responsibility of notifying SJU of any requirement by my insurance company of pre-authorization prior to any hospital admission or surgical procedure, whether done in office or in hospital. I understand that it is also my responsibility to verify that a pre-auth has been completed prior to any hospital admission or surgical procedure. I also understand if I fail to obtain a referral, if necessary, I will be responsible for the charges.

Patient /Parent/ Guardian Signature: _____

Date: _____

Patient History Form

Last Name:_____ First Name:_____ Middle_____

Reason for visit: _____

Constitutional
Fever ☐
Chills ☐
Headache ☐
Other_____

Eyes
Blurred Vision ☐
Double Vision ☐
Pain ☐
Other_____

Allergic/Immunologic
Drug ☐
Food ☐
Environmental ☐
Other_____

Neurological
Tremors ☐
Dizzy Spells ☐
Numbness ☐
Other_____

Endocrine
Excessive Thirst ☐
Too hot/cold ☐
Tired/sluggish ☐
Other_____

Gastrointestinal
Abdominal Pain ☐
Nausea/Vomiting ☐
Heartburn ☐
Other_____

Cardiovascular
Chest Pain ☐
Varicose Veins ☐
High Blood Pressure ☐
Other_____

Integumentary
Skin Rash ☐
Boils ☐
Persistent Itch ☐
Other_____

Musculoskeletal
Joint Pain ☐
Neck Pain ☐
Back Pain ☐
Other_____

Ear/Nose/Throat/Mouth
Ear Infection ☐
Sore Throat ☐
Sinus Problems ☐
Other_____

Genitourinary
Urine Retention ☐
Painful Urination ☐
Frequency ☐
Other_____

Respiratory
Wheezing ☐
Frequent Cough ☐
Shortness of Breath ☐
Other_____

Hematologic
Swollen Glands ☐
Blood Clotting Problem ☐
Other_____

Psychologic
Anxiety ☐
Depressed ☐
Satisfied with life ☐
Other_____

Non RX drugs Yes☐ No☐
Herbs Yes☐ No☐
Vitamins Yes☐ No☐

Do you smoke? _____ How much? _____ Do you drink alcohol?_____ How much? _____
Do you use recreational drugs? _____ What Kind? _____

Family Medical History (List all serious illnesses in your immediate family i.e. Mother, Father, Grandparents)

List ALL of your Medical Conditions

Personal Surgical History with dates

List All Prescription Medication You Take, Include dose and frequency.

Do you have allergies? Yes☐ No☐ Please List

SAN JUAN UROLOGY ASSOCIATES P.C.
CRAIG A. PETERSON MD

904 South 4th Street
Montrose, CO 81401
Phone—970-249-2291
Fax---970-240-3912

Appointment Cancellation/No Show Policy

The policy of this office is to encourage patients to give us at least 24 hours notice of cancellation of any appointment.

If any new patient fails to appear or cancel an appointment without 24 hour notification, a $50.00 fee will be applied to your account, with reasonable consideration of circumstances, (unforeseen emergencies or sickness.)
This charge is not covered by any insurance plan, therefore you will be personally Responsible for this fee before further appointments are scheduled.

This policy also applies to established patients, there will be a $25.00 fee applied to their account if 24 hour notice is not given.

My signature below indicates that I understand and will abide by this policy

_____

Please print Patient Name

_____

Signature of Patient/Guardian

_____

Date

Authorization for Release of PHI (Private Health Information)

Please list names of people (family members/friends) that San Juan Urology can talk to in regards to your health information should they call or come in. Without your authorization San Juan Urology can talk to NO ONE regarding your health information. Please list all names below.

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

DOB: _____

IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

San Juan Urology

Effective April 14, 2003, revised federal regulations restrict the use and disclosure of your private health information (PHI) by our practice and other organizations. IT has been, and continues to be, the policy of our practice to protect the privacy of our patient's health information and to comply with any regulations regarding the use and disclosure of patient health information. The following summarizes the new law and under what circumstance it may be disclosed.

Permitted Disclosures

Our practice is permitted to use and disclose your PHI for treatment, payment and health care operation purposes. These uses include sharing your PHI with other health car providers for confirmation of a diagnosis, using your PHI to accurately bill services we provide to you, providing your PHI to your insurance company for reimbursement, to remind you of appointments and as part of our quality improvement program.

Restricted Disclosures

You have the right to request restrictions on certain uses and disclosures of your PHI and to request portions of your PHI be amended. However, our practice is not obligated to agree to requested restrictions or to amend your PHI in the manner you request. You also have the right to inspect and receive a copy of your PHI, but must pay a reasonable charge for the labor and costs associated with copying your PHI. Finally, you have a right to receive an accounting of disclosures of your health information.

Authorization for Other Uses

Our practice will make other uses and disclosure of your protected health information **only** after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing that you wish to revoke your authorization.

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacting Jimmie Voehringer, 904 South 4th Street, Montrose, Colorado 81401, 970-249-2291 or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

Acknowledgement

I acknowledge that I have received this summary and a copy of the Notice of Privacy Practices regarding the use and disclosure of my health information.

_____

Patient Signature Date

Could your male urinary symptoms be caused by BPH?

Answer these simple questions and share them with your doctor.

American Urological Association (AUA) Symptom Index for BPH

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. INCOMPLETE EMPTYING Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. FREQUENCY During the last month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. INTERMITTENCY During the last month, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. URGENCY During the last month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM During the last month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING During the last month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5

	Never	1 time a night	2 times a night	3 times a night	4 times a night	5 times or more a night
7. NOCTURIA During the last month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Now add up your Symptom Score (1–7 Mild, 8–19 Moderate, 20–35 Severe): ☐

Name and date:

Adapted from American Urological Association. *Guideline on the Management of Benign Prostatic Hyperplasia (BPH)*. Linthicum, MD: American Urological Association Education and Research, Inc; 2003:1-22,1-23,3-51.

The Disease Specific Quality of Life Question

The International Prostate Symptom Score uses the same 7 questions as the AUA Symptom Index (presented above) with the addition of the following Disease Specific Quality of Life Question (bother score) scored on a scale from 0 to 6 points (delighted to terrible).

	Delighted	Pleased	Mostly satisfied	Mixed	Mostly disappointed	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	⓪	①	②	③	④	⑤	⑥