



PH: 541 772 6600 FX: 541 779 1266 □ UROLOGYASSOCIATESLLP.COM □ 2900 DOCTORS PARK DR. SUITE 100, MEDFORD, OR 97504

PRACTICE LIMITED TO ADULT AND PEDIATRIC UROLOGY

Dear _____

Attached are registration and health history forms. **Please complete these forms and bring them with you to your next appointment on:**

Date _____

With: **Dr. Tim Driver**

Dr. Eric Martin

Dr. James Loos

Please arrive at our office fifteen minutes prior to your scheduled appointment time if your appointment is at 8:30 AM and you did not receive a new patient packet at home to fill out in advance. Please be prepared to provide a urine sample if possible. **You will be required to present your current insurance card(s) at the time of your visit.**

Managed Care: If your insurance requires a referral from a primary care physician or the referring physician, please be advised that it is your responsibility to contact your primary care physician or referring physician for your insurance referral for your appointment at our office. If no referral is in place you will be responsible for payment at the time of service.

Private Pay: Patients should be prepared to pay at the time of their visit. Payment plans are available on an individual basis only. Please see the business office for details.

Medicare: We will gladly submit your claim to Medicare. You will be required to sign an Advance Beneficiary Notice (ABN) that Medicare may not pay for **all** the health care costs your physician finds medically necessary. The purpose of the ABN is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself or the charges will have to be submitted to another insurance company, i.e. leg bags, Foley catheters, certain medications, etc. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.

If you're not sure what Medicare benefits are covered, please contact Medicare or review your policy benefits. If you have any questions, please see our business office. We would be happy to assist you.

Oregon Health Plan: If you have coverage through Oregon Health Plan (OHP) you must present a **current card and co-pay**, if required, at the time of your visit or your appointment will be rescheduled. If your care is managed, we need to be made aware of this when your appointment is scheduled. This will allow us time to get the necessary referral in place prior to your visit or appt. will be rescheduled.

Workers Compensation: If you are being seen for a work-related injury you must present the following: name and address of workers compensation carrier, date of injury and **active** claim number.

If you have any questions regarding your visit to our facility, please do not hesitate to call us at (541) 772-6600 or visit our website at urologyassociatesllp.com.

Sincerely,

Urology Associates of Southern Oregon, LLP

DIRECTIONS

I-5 to Exit 27. East on Barnett Road. Left on Murphy Road at the light which is just past Rogue Valley Medical Center. First right is Doctors Park Drive and the first building on the right is 2900 Doctors Park Drive. Urology Associates is located on the first floor straight ahead as you enter the building.

TIMOTHY R. DRIVER, M.D., P.C.
PHYSICIAN AND SURGEON
DIPLOMATE AMERICAN BOARD OF UROLOGY

ERIC L. MARTIN, M.D., F.A.C.S., P.C.
PHYSICIAN AND SURGEON
DIPLOMATE AMERICAN BOARD OF
UROLOGY

JAMES C. LOOS, M.D., P.C.
PHYSICIAN AND SURGEON
DIPLOMATE AMERICAN BOARD OF
UROLOGY

PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit

Today's date: _____ Name _____

Last

First

Middle

Date of birth _____ Age _____ Social Security # _____ - _____ - _____

Home Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Your Approx Weight _____ Height _____

Claustrophobic? Yes _____ No _____

Referred By _____ Reason referred _____

Marital Status _____ Spouse name _____

Last

First

Middle

I authorize that my medical care and billing may be discussed with my spouse. Yes ___ No ___ N/A ___

Or other (give name) _____

If someone other than the PATIENT is responsible for payment. Complete the following:

Name of responsible party _____ Relationship to patient _____

Address _____ Home Phone (_____) - _____ - _____

Street

City

State

Zip

In case of EMERGENCY:

Relative to contact (other than spouse) _____ Phone (_____) - _____ - _____

How do you intend to pay?

Cash _____ Cash _____ Credit Card _____ Insurance _____ Medicare _____ Welfare _____ Other _____

Primary Insurance Co. _____ Phone (_____) - _____ - _____

Name of Insured _____ Policy # _____ Group # _____

DOB _____ SS # _____ Address (if different) _____

Secondary Insurance Co. _____ Phone (_____) - _____ - _____

Name of Insured _____ Policy # _____ Group # _____

PATIENT SIGNATURE _____ DATE _____

**PLEASE NOTE: I understand that if I have an HMO type of insurance and I do not have an appropriate referral in place from my primary care physician, that I am responsible for all charges incurred at this office. And co-payments are due at the time of service, as are uncovered services, unless prior arrangements have been made with the business office. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.*



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HIPAA Compliance Form

I authorize (Name of physician/physician group) to use and disclose the health and medical information of _____ (PT. Name) for the purpose of treatment.

Payment and Health Care Operations.

Treatment: (Includes activities preformed be a physician, nurse, office staff, and other types of health care professional providing care for you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

Payment: (Includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity. Justification of charges, precertification and preauthorization).

Health Care Operations. (Includes the necessary administrative and business functions of our office).

*You may review Urology Associates "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in the lobby of our office indicating the effective day of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the current Notice. We will also provide you with a copy of the Notice upon your request.

As more explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operation purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand the I have the right to revoke this CONSENT provided that I do so in writing, except to the extent the Urology Associates has already used or disclosed the information in reliance on the CONSENT.

----- (Date) ----- (Signature of patient)

----- (Date) ----- (Signature of person author.by.law)

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years

_____ Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Life Partner _____ Common Law Spouse

Dependents: Please indicate # of each, if you have:

_____ Sons _____ Daughters _____ Stepchildren _____ Adopted _____ Foster _____ Parents _____ Grandparents

Occupation: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other

Hobbies: Please circle any that apply to you:

None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

Alcohol Consumption:

_____ None _____ Yes Occasional/Social # of drinks per day _____

Tobacco per day:

_____ None _____ Yes # _____ Packs/day _____ Cigarettes/day _____ Smokeless Tobacco

If you previously stopped, When? _____

Recreational Drugs: _____ None If yes, please list: _____

Caffeinated beverages: None Low Moderate Excessive

Recent Foreign Travel: None Americas _____ Worldwide _____

PAST MEDICAL HISTORY

Please **CIRCLE** if you **have** or **have had** any of the following diseases or conditions:

Cardiovascular

Anemia
Angina
Anorexia
Aortic Aneurysm
Aortic Regurgitation
Aortic Stenosis
Arrhythmia
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Claudication
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Enlarged Heart
Heart Attack
Heart Block
Heart Disease
Heart Murmur
Heart Valve Problem
Hemophilia
Hypertension, well controlled
Hypertension, progressive
Hypertension, severe
Leukemia
Mitral Insufficiency
Mitral Stenosis
Mitral Valve Prolapse

Rheumatic Fever
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia

Endocrine/Metabolic

Diabetes Mellitus, non-insulin dependent
Diabetes Mellitus, insulin dependent
Diabetes Mellitus, uncontrolled
Goiter
Gout
Hyperthyroidism
Hypothyroidism
Impaired Glucose Tolerance

General

Allergies
Electrical Injury
Exposure to Chemicals
Hepatitis A
Hepatitis B
Hepatitis C
Hypercholesterolemia
Hyperlipidemia
Infectious Disease
Lipid Disorder

Malaise
Obesity
Paget's Disease
PCKD
PCO
Raynaud's Syndrome
Sleep Apnea

GI

Cholecystitis
Cholelithiasis
Chronic Liver Disease
Colitis
Constipation
Colon Condition
Crohn's Disease
Diarrhea
Diverticulitis
Diverticulosis
GERD
Hemorrhoids
Hepatic Failure
Hepatitis
Hiatal Hernia
Inflammatory Bowel Disease
Liver Disease
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer

Ulcerative Colitis

GU

AIDS
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection
Chronic Renal Disease
Chronic Renal Insufficiency
Chronic Renal Failure
Crossed Fused Ectopia
Hematuria
Impotence of Organic Origin
Interstitial Cystitis
Irradiation Therapy
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones
Libido Decreased
Nephrolithiasis
Nephrotic Syndrome
Neurogenic Bladder
Orchitis
Penile Discharge
Polycystic Disease
Polycystic Kidney Disease
Prostate Cancer
Radiation or Nuclear Exposure
Recurrent UTI
Renal Cell Cancer

Renal Failure
Renal Insufficiency
Testicular Cancer
Transplant Recipient
Transitional Cell CA
Bladder
Transitional Cell CA Ureter
Undescended Testicle
(Birth)
Urinary Tract Infection
Venereal Disease

GYN/OB

Breast Cancer
Breast Disease
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Fibroids

HEENT

Blindness
Cataracts
Deviated Septum
Deafness

Ear Infections
Glaucoma
Hay Fever
Meniere's
Mumps
Sinusitis
Tinnitus
Vertigo

Musculoskeletal

Arthritis
Back Pain
Carpal Tunnel
Syndrome
Claudication
Fibromyalgia
Mortons Neuroma

**Neurological/Psychologi
cal**

ADD
ADHD
Alcoholism
Alzheimer's Disease
Anxiety
Bi-polar Disorder

Chronic Fatigue
Syndrome
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Organic Brain
Syndrome
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt

Respiratory

Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia

Pulmonary Embolism
Tuberculosis

Tumors

Brain Cell Carcinoma
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Fibrocystic Breast Disease
Gastric Cancer
Laryngeal Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Rectal Cancer
Rectal Cell Cancer
Sarcomoidosis
Testicular Cancer
Transitional Cell CA
Bladder
Transitional Cell CA Ureter
Uterine CA

Other: -----

SURGICAL HISTORY

Please CIRCLE if you have had any of the following surgeries and date of surgery:

Cadiovascular

Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery
Heart Surgery (Stents)
Heart Transplant
Pacemaker Insertion
Vein Stripping

General

Brain Surgery
Laminectomy
Lymphatic Node Dissection
Parathyroidectomy
Pilonidal Cyst Incision
Skin Grafting

GI

Appendectomy
Bariatric Surgery
Bowel Resection
Cholecystectomy
Colon Resection
EGD
EGD/Dilation Esophagus
Fissurectomy
Gastric Surgery
Hemorrhoidectomy
Ileostomy
Laparoscopy

Liver Surgery
Liver Transplant
Lumpectomy of Breast
Lysis Adhesions
Nissen Fundoplication
Splenectomy
Stomach Surgery
Umbilical Hernia
Ventral Hernia Repair

GU

Bladder Surgery
Biopsy Prostate
Brachytherapy
Circumcision
Contigen
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-
Retrograde
Cystoscopy-Stent
Cysto-TUR Fulguration
Durasphere
Epididymectomy
ESWL
Herniorrhaphy
Hydrocelectomy
Ileal conduit
Indigo Laser Surgery
Inguinal Herniorrhaphy
Interstim
Kidney Stone

Laser Lithotripsy
Meatotomy
Needle Biopsy Prostate
Nephrectomy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Implant
Penectomy
Penile Surgery
Pyeloplasty
Radical Prostatectomy
Renal Transplant
Spermatocectomy
TUMT Prostate
TUNA Prostate
TURBT
TUR Prostate
Ureteroscopy
Variocelectomy
Vasectomy
VLAP

HEENT

Cataract Surgery
Corneal Surgery
Ear Surgery
Eye Surgery
Facial Surgery
Mastoid Surgery
Nasal Surgery
PEG

PE Tubes
Septoplasty
Sinus Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery

Musculoskeletal

Amputation
Arthroscopic Knee Surgery
Back Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Hip Surgery
Knee Surgery
Leg Surgery
Rotator Cuff Surgery
Shoulder Surgery

Respiratory

Lung Surgery

Skin

Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

Other: -----

FAMILY HISTORY

Please CIRCLE and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle , Aunt)

Arthritis _____
 Bedwetting _____
 Bladder Cancer _____
 Cancer (site unknown) _____
 Crohn's Disease _____
 Depression _____
 Diabetes _____
 Gout _____
 Heart Attack _____
 Hypertension _____
 Kidney Cancer _____
 Kidney Disease _____

Leukemia _____
 Malignant Melanoma _____
 Multiple Sclerosis _____
 Laryngeal Cancer _____
 Pancreatic Cancer _____
 Prostate Cancer _____
 Stroke _____
 Thyroid Disease _____
 Tuberculosis _____
 Other: _____
 Other: _____
 Other: _____

REVIEW OF SYSTEMS FOR PATIENT ONLY:

Constitutional

Appetite Changes
 Anorexia
 Aches and Pains
 Chills
 Easy Bruising
 Fever
 Fatigue
 Generalized Weakness
 Insomnia
 Night Sweats
 Sleep Apnea
 Swollen Glands
 Weight Gain
 Weight Loss

Eyes

Blind
 Blurred Vision
 Double Vision
 Glaucoma
 Pain
 Worsening Eyesight

Allergic/Immunologic

Animal Allergies
 Drug Allergies
 Environmental Allergies
 Food Allergies
 Seasonal Allergies

Neurological

Balance Problems
 Disoriented
 Dizzy Spells
 Headache
 Lack of Alertness
 Leg or Arm Weakness
 Memory Loss
 Numbness/Tingling
 Stroke
 Speech Problems

Tremors

Endocrine

Diabetes
 Excessive thirst
 Pituitary Disease
 Thyroid Disease
 Tired/Sluggish
 Too Hot/Cold

Gastrointestinal

Abdominal Cramps
 Abdominal Pain
 Acid Reflux
 Bloody Stools
 Change in Bowel Habits
 Constipation
 Diarrhea
 Flatulence
 Gas
 Hemorrhoids
 Indigestion/heartburn
 Irregular Bowel Movements
 Nausea/vomiting
 Rectal Bleeding
 Tarry Stool

Cardiovascular

Chest Pain/Angina
 Dyspnea on Exertion
 Edema
 Heart Attack
 Heart Failure
 Heart Murmur
 High Blood Pressure
 Irregular Heart Beat
 Mitral Valve Prolapse
 Orthopnea
 Pain/Cramps
 Hips/Legs w/exercise

Palpitation
 Skipped Heart Beats
 Swelling

Skin

Acne
 Boils
 Changing Moles
 Persistent Itch
 Pigment Change
 Skin rash

Musculoskeletal

Arthritis
 Back Pain
 Gout
 Joint Pain
 Muscle Cramps
 Muscle Weakness
 Neck Pain/Stiffness

Ear/Nose/Throat

Ear Infection
 Sinus Problem
 Sore Throat

Genitourinary

Back Pain
 Bedwetting
 Blood in Urine
 Dribbling
 Burning on Urination
 Erection Problems
 Flank Pain
 Hematuria
 Hesitancy
 Kidney Failure
 Kidney Infections
 Kidney Stones
 Leak after voiding
 Nocturia
 Nocturnal Enuresis

Not Emptying
 Painful Ejaculation
 Stranguria
 Stones
 Suprapubic Pain
 Urgency
 Urinary Frequency
 Urinary Hesitancy
 Urinary Incontinence
 Urinary Tract Infections
 Urine retention
 Urologic Cancer
 Urologic Surgery
 Vaginal Bleeding
 Vaginal Discharge/Problems
 Weak Stream

Respiratory

Asthma
 Emphysema-Bronchitis
 Environmental Allergies
 Frequent Cough
 Pneumonia
 Shortness of breath
 Tuberculosis
 Wheezing

Hematological/Lymphatic

Swollen Glands
 Blood clotting problem
 Bleeding Problem
 Hepatitis
 HIV (AIDS)
 Sickle Cell

Psychologic

Anxiety
 Depressed
 Generally satisfied with life

Other: _____