UROLOGICAL ASSOCIATES, P.C.
1644 Medical Center Pt., Suite 200
Colorado Springs, CO 80907
PH: 719-634-1994 FX: 719-622-6016

Adult & Pediatric Urology

Craig K. Carris, M.D., F.A.C.S.
Diplomate
American Board of Urology

Elliot J. Cohn, M.D.
Diplomate
American Board of Urology

Benjamin J. Coons, M.D.
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Michael M. Crissey, M.D.
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J. Eric Derksen, M.D.
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Jeffrey K. Ferguson, M.D.
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Brett R. Jepson, M.D.
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James A. Simon, M.D.
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James R. Thomasch, M.D.
Diplomate
American Board of Urology

Joanna V. Jones, NP·C
AANP

Stacen G. Jones, MBA
Practice Manager

New Patient Form

This 8 page form contains the necessary paperwork needed for your office visit. We appreciate your due diligence in getting your paperwork back to us prior to your visit. If you wish to arrive only 15 minutes prior to your appointment time then we will need to receive your completed paperwork at least 24 hours prior to your appointment. To achieve this you can either:

1. **Complete this form** by typing in the spaces with your answers. You will be instructed on the last page to save this form to your computer and email to our office as an attachment.
2. **Print, fill out and Fax** the completed paperwork to our office prior to your appointment. Fax number: 719-622-6016.
3. **Mail it back** to us in enough time for it to arrive before your appointment.
4. **Drop it off** at our office prior to your appointment.

If we do not receive your paperwork at least 24 hours prior to your appointment, then you will need to arrive 45 minutes prior to your appointment time with your completed paperwork in hand so we can input your information electronically. If we do not receive the completed paperwork in advance of your appointment, or if you arrive at your appointment time and the paperwork is not completed, **your appointment will be rescheduled.**

Insurance

In order to properly bill for your visit, please bring your insurance card/cards with you. We will need to scan these for billing purposes. If you have new insurance and have not received your card, you will need to bring all necessary **proof of insurance**, in order to properly bill for services. **If you do not bring this information, you will be expected to pay for all charges the day of your appointment**.

Payment of Services

For those with insurance, your **specialist copay will be collected when you check in** for your appointment. If you ***DO NOT*** have insurance, **we will expect payment for the services on the day of your appointment.** We accept Visa, MasterCard, Discover, Amex, cash and checks.

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Referral Policy

Upon receiving your authorization/referral, our office will contact you to schedule an appointment. If your insurance requires an authorization/referral to be seen by one of our providers, this will be your responsibility to make sure our office has received this prior to scheduling an appointment. In addition, you will be responsible for any payment for services that our practice provides when an authorization/referral was required and was not obtained prior to scheduling your appointment.

Notice of Privacy Practice

In compliance with HIPPA regulations, our office has the NPP policies posted on our website for your review or you may ask for a copy at the front desk.

Cancellation, No Show or Late Appointment Policy

We will call and confirm your appointment 24 hours in advance. If your schedule changes, please call our office prior to **24** hours out from your appointment to cancel. If you **do not call to cancel, and/or do not show up for your appointment,** you will be billed a **$100** administration fee for the missed appointment. In addition, if you are late for your appointment, you will be rescheduled. **We work hard to stay on schedule however, emergencies do arise creating unforeseen delays. We apologize for any inconvenience in the event your appointment is delayed.**

You will be asked to leave a urine specimen when the nurse takes you back to see the doctor. If you feel you cannot wait until you are called, see the receptionist for instructions.

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Surgery and Procedure Reschedule, Cancellation and No-Show Policy

Rescheduling or Canceling

It is important that when you schedule your surgery/procedure you have thoroughly checked your personal calendar to make sure that your scheduled date is ideal for you. Canceling or rescheduling your surgery/procedure requires multiple phone calls to the hospital or outpatient facility, insurance company, and patient. We understand that a situation may arise that could force you to reschedule, postpone or cancel your surgery/procedure. Colorado Springs Urological Associates will reschedule a surgery/procedure one time at no charge. Beyond that, **there will be a $50 charge each time a surgery/procedure is rescheduled. This fee will not be applied toward your surgery/procedure and will be added as a charge to your account, not billable to insurance.** This fee must be paid to Colorado Springs Urological Associates prior to surgery/procedure being rescheduled.

No-Show Policy

If you do not show up for a scheduled surgery/procedure you will be charged a $400.00 administration fee for the cost of the surgery.

We appreciate your understanding of the above stated policy and thank you for your cooperation.

Thank You

Thank you for scheduling an appointment with Urological Associates. We look forward to meeting you. If you have any questions, please contact our office between 8:00 a.m. and 4:30 p.m., Monday-Friday.

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Patient Information

DATE

NAME DATE OF BIRTH AGE

MAILING ADDRESS

CITY STATE ZIP

STREET ADDRESS *(IF DIFFERENT)* CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE

SS# SEX (SELECT ONE) ■ M ☐ F

EMPLOYER'S NAME AND ADDRESS

INSURED'S NAME (IF OTHER THAN PATIENT OR IF PATIENT IS A MINOR)

NAME DATE OF BIRTH

MAILING ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE SS#

RELATIONSHIP TO PATIENT MARITAL STATUS: ■ S ☐ M ☐ D ☐ W SPOUSE'S NAME

EMPLOYER'S NAME AND ADDRESS

INSURANCE (PLEASE BRING YOUR DRIVERS LICENSE AND INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT)

PRIMARY:	SECONDARY:
COMPANY	
ID NO.	
GROUP NO.	

THE FOLLOWING INFORMATION IS MANDATORY

WHO IS THE PATIENT'S PRIMARY CARE PHYSICIAN? PHONE

NAME OF PHYSICIAN WHO REFERRED YOU HERE PHONE

EMERGENCY CONTACT NOT RESIDING WITH THE PATIENT PHONE

I hereby authorize Urological Associates, P.C. to provide medical treatment services to me and/or my dependents, and use my Personal Health Information to file a claim for service with your insurance company. In doing so, I assign to the physicians all payments for medical services provided. I understand that I am responsible for any amount not covered by my insurance. I also understand that if I do not have insurance, I am responsible for all charges associated with my visit to be paid in full on the day of my visit.

SIGNATURE DATE

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Patient Name _____ Date _____

Consent To Use And Disclose Protected Health Information

Protected health information (PHI) will be disclosed or used by Urological Associates for the purposes of treatment, obtaining payment, or supporting day-to-day health care operations.

I understand that I have a right to request restrictions of the uses and disclosures of my PHI for the above stated purpose. But you are not required to agree with these restrictions.

If you would like to view the Notice of Privacy Practices for more detailed information just ask the receptionist for the binder with this information in it or you may view it on our website at www.urologicalassoc.com.

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

Our office may need to contact you regarding information pertaining to your treatment. If we are unable to reach you, it may be necessary to leave a message. These messages may contain confidential information not intended for others. To avoid any breach in confidentiality, please review the choices below and check those that apply:

☐ YES, THE DOCTOR'S OFFICE MAY LEAVE MESSAGES ON MY ANSWERING MACHINE/VOICE MAIL.

☐ NO, DO NOT LEAVE ANY MESSAGES. ☐ I HAVE NO ANSWERING MACHINE.

In some cases it is helpful for a spouse or family member to be informed of your medical care, to include test results. Please mark yes or no below.

☐ NO, DO NOT DISCUSS MY MEDICAL CARE WITH ANYONE OTHER THAN ME.

☐ YES, YOUR OFFICE MAY DISCUSS MY MEDICAL CARE WITH THE NAMES LISTED BELOW:

PHONE # _____ RELATIONSHIP TO PATIENT _____

NAME _____

SIGNATURE OF PATIENT / GUARDIAN _____ DATE _____

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Patient Name _____ Date _____

Past Medical History

Please check all that apply:

	Onset date MM/YY
☐ Abdominal Aortic Aneurysm	
☐ Alcohol Withdrawal	
☐ Anemia	
☐ Angina Pectoris (chest pain)	
☐ Aortic Valve Disease	
☐ Aortic valve replacement	
☐ Appendicitis	
☐ Asthma	
☐ Backache	
☐ Bladder Cancer	
☐ BPH (enlarged prostate)	
☐ Breast Neoplasm, Malignant (cancer)	
☐ Bronchitis	
☐ Cardiac Dysrhythmia (irregular heartbeat)	
☐ Carotid Stenosis	
☐ Cataracts	
☐ Cervical Cancer	
☐ Cesarean Delivery	
☐ Cholelithiasis (gall stones)	
☐ Chronic Prostatitis	
☐ Chronic Renal Failure	
☐ Coagulation Defect (bruise easily)	
☐ Colitis, Ulcerative	
☐ Colon Cancer	
☐ Congestive Heart Failure	
☐ COPD	
☐ Crohn's Disease	
☐ CVA (stroke)	
☐ Cystitis (bladder infections)	
☐ Cystocele	
☐ Cystoscopy	
☐ Diabetes Mellitus, Type I, IDDM (insulin dependent)	
D Diabetes Mellitus, Type II	

	Onset date MM/YY
☐ DVT (blood clot in legs)	
☐ Dyspareunia (painful intercourse)	
☐ Elevated Blood Pressure Rating	
☐ Elevated prostate specific antigen	
☐ Emphysema	
☐ Fibromyalgia	
☐ Frequent UTIs	
☐ Gastro Esophageal Reflux-GERD	
☐ Glaucoma	
☐ Head Injury	
☐ Heart Disease	
☐ Heart Failure	
☐ Hematuria (blood in urine)	
☐ Hepatitis	
☐ HIV / AIDS	
☐ Hormone Replacement Therapy	
☐ Incontinence (leakage)	
☐ Infection of Kidney	
☐ Kidney stones	
☐ Kidney x-ray (IVP)	
☐ Mitral valve repair	
☐ Multiple Sclerosis	
☐ Myocardial Infarction (heart attack)	
☐ Neuropathy	
☐ Nocturnal Enuresis (bedwetting)	
☐ Parkinson's Disease	
☐ Peripheral Vascular Disease	
☐ Prostate Cancer	
☐ Senile Dementia	
☐ Sleep Apnea	
☐ Testicular Cancer	
☐ Urethral Stricture	
☐ Other	
Other	

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Patient Name _____ Date _____

Medical History

Please complete your past medical, social, and family history.

If male, have you had a PSA blood test? ☐ Y ☐ N If yes, please list result and date _____

Please list any surgical procedures:

TYPE OF SURGERY	YEAR	HOSPITAL	SURGEON

Please list all medicines and doses:

	MEDICINE	DOSAGE AMOUNT
1.		
2.		
3.		
4.		
5.		
6.		

Please list allergies/reactions to medications.

	ALLERGY	REACTION
1.		
2.		
3.		
4.		
5.		
6.		

Name and location of preferred pharmacy _____

Is there a family history of:

BEDWETTING	Y ☐ N ☐	WHO?	AGE AT ONSET?	
DIABETES	Y ☐ N ☐	WHO?	AGE AT ONSET?	
KIDNEY FAILURE	Y ☐ N ☐	WHO?	AGE AT ONSET?	
KIDNEY STONES	Y ☐ N ☐	WHO?	AGE AT ONSET?	
PROSTATE CANCER	Y ☐ N ☐	WHO?	AGE AT ONSET?	

HAVE YOU SMOKED TOBACCO PRODUCTS? Y ☐ N ☐ CURRENT USER ☐ FORMER USER ☐

HOW MANY YEARS DID OR HAVE YOU SMOKED? _____

DO YOU USE CAFFEINE? Y ☐ N ☐ IF YES, HOW MANY CUPS PER DAY? _____

DO YOU DRINK ALCOHOL? Y ☐ N ☐ IF YES, DESCRIBE USE: MILD ☐ MODERATE ☐ HEAVY ☐

TRAVEL OVERSEAS? Y ☐ N ☐ WHEN? _____ WHERE? _____

OCCUPATION _____

RETIRED? Y ☐ N ☐ SEMI ☐

ARE YOUR PARENTS LIVING? Y ☐ N ☐

IF NOT, AGES AT TIME OF DEATH AND CAUSE: Mother _____ Father _____

Women Only Health Section

NUMBER OF CHILDREN _____ NUMBER OF PREGNANCIES _____ ARE YOU ON BIRTH CONTROL? Y ☐ N ☐

DO YOU HAVE IRREGULAR PERIODS? Y ☐ N ☐ DO YOU HAVE PAINFUL PERIODS? Y ☐ N ☐

ARE YOU SEXUALLY ACTIVE? Y ☐ N ☐

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Patient Name _____ Date _____

Reason For Your Visit

Chief Complaint
What is the main reason for your visit today? _____

Have you ever seen a Urologist before? Y ☐ N ☐ IF YES, WHO & WHEN? _____

History of Present Illness:
WHEN DID YOU FIRST NOTICE THE PROBLEM? DATE: (MM/YYYY) _____
IS THE PROBLEM CONTINUOUS OR DOES IT COME AND GO? _____
DOES ANYTHING MAKE YOUR PROBLEM WORSE OR BETTER? Y ☐ N ☐ WHICH? WORSE ☐ BETTER ☐
RATE THE SEVERITY OF YOUR PROBLEM FROM 1-10 _____

Review of Systems
DO YOU CURRENTLY HAVE ANY PROBLEMS LISTED BELOW: (PLEASE CHECK ONE)

Constitutional Symptoms
WEIGHT LOSS Y ☐ N ☐
FEVER Y ☐ N ☐
CHILLS Y ☐ N ☐
OTHER _____

Eyes
BLURRED VISION Y ☐ N ☐
EYE PAIN Y ☐ N ☐
OTHER _____

Cardiovascular
CHEST PAIN Y ☐ N ☐
RAPID HEARTBEAT Y ☐ N ☐
OTHER _____

Respiratory
SHORTNESS OF BREATH Y ☐ N ☐
FREQUENT COUGH Y ☐ N ☐
OTHER _____

Gastrointestinal
CONSTIPATION Y ☐ N ☐
DIARRHEA Y ☐ N ☐
ABDOMINAL PAIN Y ☐ N ☐
VOMITING Y ☐ N ☐
OTHER _____

Genitourinary
BLOOD IN URINE Y ☐ N ☐
URINARY FREQUENCY Y ☐ N ☐
BURNING ON URINATION Y ☐ N ☐
URINARY LEAKAGE Y ☐ N ☐
BEDWETTING Y ☐ N ☐
DIFFICULTY WITH INTERCOURSE Y ☐ N ☐
URINARY URGENCY Y ☐ N ☐
OTHER _____

Neurological
TREMORS Y ☐ N ☐
LOSS OF BALANCE Y ☐ N ☐
MEMORY LOSS Y ☐ N ☐
OTHER _____

Musculoskeletal
JOINT PAIN Y ☐ N ☐
BONE PAIN Y ☐ N ☐
BACK PAIN Y ☐ N ☐
OTHER _____

Endocrine
HEAT INTOLERANCE Y ☐ N ☐
COLD INTOLERANCE Y ☐ N ☐
INCREASED THIRST Y ☐ N ☐
OTHER _____

Hematologic
EASILY BRUISED Y ☐ N ☐
SWOLLEN LYMPH NODES Y ☐ N ☐
EASY BLEEDING Y ☐ N ☐
OTHER _____

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Urinary Symptom Index Questionnaire

(Check the box by the number that best applies to you for each question)

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

	None	1 time	2 times	3 times	4 times	5 or more
7. 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

Add up all numbers circled above and write the total in the space to the right.
SYMPTOM SCORE = 1 - 7 = Mild 8 - 19 = Moderate 20 - 35 Severe

YOUR TOTAL ☐

Quality of Life

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Thank you for completing this form. Please save it to your desktop after completion.
Then email it as an attachment to forms@urologicalassoc.com.

Please open the attachment before emailing it to us to make sure the form saved properly to your computer with the completed information. If you cannot accomplish these steps please simply print the form and drop it off or mail it to us at 1644 Medical Center Point #200, Colorado Springs, CO 80907, or fax it to: (719) 622-2016. If your attachment is blank you may not have Adobe Reader installed on your computer. If that happens, or if you have any questions please call us at 719-219-3172.