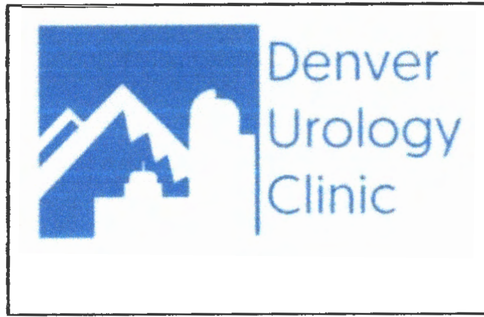
Thornton

9141 Grant St Suite 245

Thornton, CO 80229

Phone: 303-388-9321



Boulder

1840 Folsom St Suite 105

Boulder, CO 80302

Fax: 303-388-3910

PATIENT INFORMATION (Patient to fill out)

Last Name: ____________________ First Name: ____________________ M.I.: ______

Address: ____________________ Apt/Suite #: ________ City: ____________ State: ______ Zip: ________

Date of Birth: ____/____/______ Social Security #: _____-_____-______ Marital Status: M / D / S / W

Sex: M / F

Home Phone: (____)__________ Cell Phone: (____)__________ Work Phone: (____)__________

☐Ok to get text messages regarding appointment reminders

Employer: ____

How did you hear about us? Insurance / Internet / Friend / Doctor / Other __________

Email Address: ____________________ How do you prefer to be contacted? __________

Pharmacy: ____________________ Pharmacy Phone: (____)__________

Emergency Contact: Name ______________ Relationship ______________ Phone __________

GUARANTOR INFORMATION (Patient or Guardian to fill out)

If other than patient: Name: ______________ Date of Birth: __________ Social Security #: ____-____-____

Address: ____________________ Apt/Suite #: ________ City: ____________ State: ______ Zip: ________

Home Phone: (____)__________ Cell Phone: (____)__________ Work Phone: (____)__________

PROVIDER INFORMATION (Patient to fill out)

Primary Care Physician: ____________________ Phone Number: __________

Referring Physician: ____________________ Phone Number: __________

Other Physician: ____________________ Other Physician: ____________________

INSURANCE INFORMATION (Staff to fill out)

Primary Insurance Plan: ____________________ Effective Date: __________

Policy #: ____________________ Group #: __________

Policy Holder Name: ______________ Date of Birth: __________ Copay $: __________

Secondary Insurance Plan: ____________________ Effective Date: __________

Policy #: ____________________ Group #: __________

Policy Holder Name: ______________ Date of Birth: __________ Copay $: __________

Name: ______________________ Age ___ Height ______ Weight ______ Today's Date: ____________

Reason's for today's visit: ____

PAST MEDICAL HISTORY: Please select all that apply:

☐ High blood pressure ☐ High cholesterol ☐ Heart attack ☐ Heart failure ☐ Asthma ☐ COPD

☐ Esophageal reflux (GERD) ☐ Cirrhosis ☐ Hepatitis A/B/C ☐ Irritable bowel syndrome ☐ Colitis

☐ Crohn's Disease ☐ Stroke ☐ Epilepsy/Seizures ☐ Multiple sclerosis ☐ Head Injury ☐ Depression

☐ Anxiety Disorder ☐ Diabetes ☐ Hypothyroidism ☐ Anemia ☐ Clotting or bleeding problems

☐ Lupus ☐ DVT ☐ Fibromyalgia ☐ HIV / AIDS ☐ Arthritis (type) ____________________

☐ Gonorrhea ☐ Tuberculosis ☐ Syphillis ☐ Mumps ☐ Herpes ☐ Recurrent UTIs

☐ BPH ☐ Overactive bladder ☐ Cancer (type) ______ ☐ Other ____________________

☐ Other ____________ ☐ Other ____________ ☐ Other ____________________

PAST SURGICAL HISTORY: Please list all operations you have had:

Operation	Date	Operation	Date

MEDICATIONS: Please list any medicines (including aspirin and herbal remedies) that you now take:

ALLERGIES: Are you allergic to any medicines, iodine, tape, or anesthesia? Yes No If yes, please list below:

Allergy	Reaction	Allergy	Reaction

SOCIAL HISTORY:

What is/was your occupation? ____________ Marital Status: Single Married Divorced Widowed

Do you currently smoke? Yes No If yes, how much and how often? ______ If you stopped, when did you stop? ______

Have you ever smoked? Yes No

Do you drink alcohol? Yes No If yes, how much and how often? ____________________

Do you use any other drugs? Yes No

If 65 years or older, do you have an Advanced Care Plan or surrogate decision maker? Yes No

If yes, does your primary care physician have this document on file? Yes No

Are your parents alive? Yes No If yes, age of mother? ____________ Age of father? ________

If no, cause of death of mother? ____________________ Age at death? ________

If no, cause of death of father? ____________________ Age at death? ________

Do you need to take antibiotics prior to dental procedures (for heart murmur or other reason)? Yes No

Have you had any unexplained weight changes? Yes No Describe: ____________________

FAMILY HISTORY: Please indicate if any family member has had the following:

☐ Kidney cancer ☐ Prostate cancer ☐ Bladder cancer

☐ Kidney stones ☐ High blood pressure ☐ Bleeding or clotting problems

☐ Kidney disease ☐ Heart disease ☐ Problems with anesthesia

☐ Kidney infections ☐ Stroke ☐ Other

REVIEW OF SYSTEMS:

Number of pregnancies _______ Number of live births _________ Vaginal deliveries _____ C-Sections ___________

Constitutional: ☐ Fever ☐ Chills ☐ Malaise/fatigue ☐ Night sweats ☐ Unexpected weight gain/loss

Eyes: ☐ Blurred vision ☐ Double vision ☐ Photophobia ☐ Glaucoma ☐ Eye pain ☐ Redness of eyes

Ears: ☐ Hearing loss ☐ Ear pain ☐ Sensation of room spinning ☐ Tinnitus

Nose: ☐ Nasal congestion ☐ Abnormal sneezing ☐ Nose bleeds ☐ Postnasal drip

Mouth/Throat: ☐ Oral ulcers ☐ Oro-dental problems ☐ Sore throat ☐ Swollen glands (neck) ☐ Sensation of lump in throat

Cardiovascular: ☐ Chest pain ☐ Heart murmur ☐ Palpitations ☐ Claudication ☐ Dyspnea ☐ Orthopnea ☐ Edema ☐ Last EKG: _____

Respiratory: ☐ Cough ☐ Shortness of breath ☐ Chest tightness ☐ Hemoptysis ☐ Asthma ☐ Wheezing

Gastrointestinal: ☐ Nausea/vomiting ☐ Bowel habits change ☐ Diarrhea ☐ Constipation ☐ Abdominal pain ☐ Difficulty swallowing ☐ Blood in stools ☐ Hemorrhoids ☐ Heartburn

Genitourinary: ☐ Blood in urine ☐ Excessive nighttime urination ☐ Urinary frequency ☐ Hesitancy ☐ Urinary urgency ☐ Dribbling urine ☐ Decreased urine stream ☐ Abnormal discharge ☐ Burning ☐ Itching ☐ Dyspareunia ☐ UTI / bladder / kidney infection ☐ Hot flashes/night sweats ☐ Breast tenderness ☐ Breast lumps ☐ Abnormal vaginal discharge ☐ Pain in testicles ☐ Lumps in testicles ☐ Difficulty with erection/ejaculation ☐ Abnormal discharge from penis

Musculoskeletal: ☐ Joint pain ☐ Neck pain ☐ Shoulder pain ☐ Back pain ☐ Upper extremity pain ☐ Lower extremity pain ☐ Sensation of numbness/tingling in extremities

Integumentary (Skin): ☐ Itching ☐ Rashes ☐ Change in skin color ☐ Change in hair/nails ☐ Varicose veins

Neurological: ☐ Seizures ☐ Headache ☐ Dementia ☐ Weakness ☐ Tremors ☐ Loss of balance ☐ Head injury ☐ Paralysis ☐ Decrease in cognitive skills

Psychiatric: ☐ Difficulty concentrating ☐ Insomnia ☐ Changes in socializing ☐ Irritability ☐ Mood changes ☐ Suicidal thoughts/attempts ☐ Anxiety ☐ Depression ☐ Nervousness ☐ Forgetfulness ☐ Adequate/sound sleep ☐ Previous use of psychotropic medication

Endocrine: ☐ Excessive urination ☐ Cold intolerance ☐ Change in hat/glove size ☐ Nocturia ☐ Glandular/hormonal problems ☐ Dry skin

Hematologic: ☐ Anemia ☐ Easy bruising ☐ Malaise/fatigue ☐ Night sweats ☐ Slow healing wounds ☐ Past transfusions ☐ Phlebitis

Activities of Daily Living: ☐ Bladder incontinence ☐ Bowel incontinence ☐ Able to go to toilet independently ☐ Able to feed self independently ☐ Able to dress self independently ☐ Able to bathe independently ☐ Needs wheelchair ☐ Able to prepare meals independently ☐ Able to shop independently ☐ Able to manage medications independently ☐ Able to handle money matters independently ☐ Able to use telephone independently ☐ Able to do light work unassisted ☐ Able to do heavy work unassisted ☐ Able to travel independently

Have you been screened for colon cancer with a colonoscopy? ☐ Yes ☐ No Date: ____________________
Have you ever received a pneumococcal vaccine? ☐ Yes ☐ No Date: ____________________
Have you received a flu vaccine within the last year? ☐ Yes ☐ No Date: ____________________
Have you ever been screened for breast cancer? ☐ Yes ☐ No Date: ____________________
Women: Have you ever been screened for cervical cancer? ☐ Yes ☐ No Date: ____________________

DENVER UROLOGY CLINIC, P.C.

North Suburban Hospital
9141 Grant St, Ste 245
Thornton, Colorado 80229

Jeremy L. Weiss, DO
John L. Logan, MD

Telephone: (303) 388-!
Fax: (303) 388-3910
www.denverurologyclinic.com

OFFICE POLICIES

MISSED APPOINTMENTS

In order to better serve all our patients, we ask that if you need to cancel or reschedule an appointment, you provide a minimum of 24 hours notice. In the event that you do not provide the 24 hours notice prior to cancelling an appointment, you will be charged a missed appointment fee of $35.00. This fee is not billable to insurance and will require payment prior to your next scheduled appointment.

MEDICAL RECORDS PROCESSING

Should you require copies of your medical records, please be aware that there is a medical records processing fee. The fee is determined in accordance with HIPPA. "Reasonable fees" are defines as:

- $18.53 for the first 10 pages
- $0.85 for the next 30 pages
- $0.57 for each additional page

Additionally, the medical provider may charge the actual postage, electronic media costs, if applicable, and applicable taxes as well of a fee of $10 for certification of the medical records.

Colorado Revised Statutes § 25-1-801

PAPERWORK PROCESSING

Should you require any paperwork to be filled out including, but not limited to, insurance paperwork or FMLA paperwork, please allow 3 business days. The charge for this service will be $25.00. Should you require paperwork to be filled out the same business day, the charge will be $75.00.

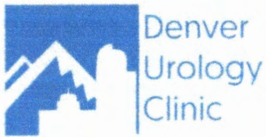
Consent to Treat

I voluntarily consent to medical treatment and procedures that may be performed on me during visits. This includes, but is not limited to, medical or surgical care, tests, medications, injections, laboratory tests, or other services which may be ordered by the provider participating in my care.

FINANCIAL POLICIES

All charges for services rendered are due and payable at the time of service unless we are a contracted provider with your insurance company. You must provide us with your insurance card prior to services rendered. It is the patient's responsibility to see that the bill is paid in full. We must emphasize, as your medical care provider, our relationship is with you, the patient, and not your insurance company. The filing of a medical claim is an expensive process that we extend to you, at no charge, as a courtesy. However, we do ask that you pay all co-pays, deductibles, and non-covered charges the day of service. For surgical procedures, we may also ask that you pay an estimated co-insurance amount. Although we contact your insurance company to obtain your benefits, it is your responsibility, as the insured, to know your own benefits. We encourage you to contact your insurance company as well. We are not responsible for benefits that are misquoted to us by your insurance company. Denver Urology Clinic requires a credit or debit card, HSA (Health Savings Account) or flex spending on file with us. Your information is stored in a secure system that complies with the Payment Card Industry Data Security Standards (PCI DSS). In the instance that you have an unpaid balance that is 75+ days overdue, your card will be automatically charged. In the instance that payment is received via personal check and the check is returned as "insufficient funds," there will be an additional $40.00 returned check fee.

Patient Signature: ______________________________ Date: ______________



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Jeremy L. Weiss, DO ◆ John L. Logan, MD

RELEASE OF INFORMATION

I, ______________________________, give permission for Denver Urology Clinic to leave messages regarding **confirmation, change, and/or cancellation of my office appointment** on the answering machine, with a family member, or any adult person answering my telephone.

I give permission to leave **voicemail messages** regarding my **diagnosis, lab/radiology results** at the following numbers

Home: (__________) ______________________

Cell: (__________) ______________________

Work: (__________) ______________________

I further give permission for the office to release any medical information, including, but not limited to, **medical information concerning my diagnosis, lab/radiology results**. I authorize the release of my protected medical/personal information to the following person(s):

Name: ______________________________ Relationship: ____________________

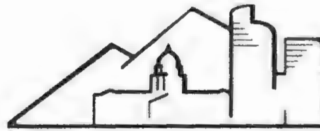
Contact Phone: ____

Name: ______________________________ Relationship: ____________________

Contact Phone: ____

____ __________

Patient or Responsible Party Signature Date



DENVER UROLOGY CLINIC, P.C.

Patient's Name: ______________________ Date of Birth: ______________

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I received, or was offered, the Notice of Privacy Practices.

____ ______________

Signature of patient or patient representative Date

Documentation of Good Faith Efforts to obtain patient's acknowledgement that they received provider's Noticy of Privacy Practices

(For use when acknowledgement cannot be obtained from the patient.)

The patient presented to the office on _____/_____/_____ and was provided with a copy of the Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Patient was unable to sign or initial because:
  ____
  ____
  ____
- ☐ The patient had a medical emergency and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ☐ Other reason (describe below):
  ____
  ____
  ____

____ ______________

Signature of employee completing form Date