PATIENT REGISTRATION

EMPLOYEE INITIALS HERE

PATIENT INFORMATION

NAME:____ TODAY'S DATE:________________________

LAST FIRST MI

SS#_________________________ GENDER AT BIRTH: MALE FEMALE GENDER IDENTITY:_________

DOB:____/____/______ AGE:_____ RACE:________________ ETHNICITY:_________________________

LANGUAGE:________________ EMAIL:____

ADDRESS:____

HOME PHONE:___________________ CELL:___________________ WORK PHONE:___________________

PRIMARY PHONE: HOME CELL WORK MAY WE LEAVE A VOICEMAIL? YES NO

MARITAL STATUS:______________ SPOUSE'S NAME:____________________ PHONE:__________________

EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED UNEMPLOYED OCCUPATION:______________

EMPLOYER NAME:______________________________ EMPLOYER PHONE:__________________________

IS PATIENT A MINOR? YES NO IF YES, NAME OF PARENT OR GUARDIAN:_________________________

PARENT/GUARDIAN ADDRESS:____

HOME PHONE:___________________ CELL:___________________ WORK PHONE:___________________

EMERGENCY CONTACT #1:___________________ RELATIONSHIP:________________ PHONE:_________________

EMERGENCY CONTACT #1:___________________ RELATIONSHIP:________________ PHONE:_________________

HAVE YOU COMPLETED AN ADVANCED DIRECTIVE? LIVING WILL DNR DURABLE POWER OF ATTORNEY

IF NO ADVANCED DIRECTIVE COMPLETE, WOULD YOU LIKE TO LEARN ABOUT THEM? YES NO

YES NO I HEREBY AUTHORIZE THE RELEASE OF MEDICAL/FINANCIAL INFORMATION TO MY EMERGENCY CONTACTS.

YES NO I ACKNOWLEDGE RECEIPT OF SOUTHEAST UROLOGY NETWORK'S PRIVACY PRACTICES EFFECTIVE 1/1/2021.

YES NO I ACKNOWLEDGE FAILURE TO SHOW FOR MY APPOINTMENT WITHOUT A 24-HOUR PRIOR NOTIFICATION WILL RESULT IN A $25.00 NO SHOW FEE.

SIGNATURE:____ DATE:_____________________________

<u>NOTICE TO PATIENTS</u>

IT IS THE RESPONSIBILITY OF EVERY PATIENT:

- **TO SUPPLY CORRECT INSURANCE INFORMATION TO THIS OFFICE. PATIENTS ARE EXPECTED TO NOTIFY THIS OFFICE OF ANY CHANGE IN CURRENT EFFECTIVE INFORMATION PRIOR TO OR AT THE NEXT VISIT AFTER THE CHANGE GOES INTO EFFECT;**
- **TO NOTIFY THE OFFICE OF ANY ADDRESS OR TELEPHONE NUMBER CHANGE;**
- **TO BRING ANY REFERRAL REQUIRED BY THEIR INSURANCE COMPANY. HAVING THIS INFORMATION FAXED THE DAY PRIOR TO OR BROUGHT ON THE DAY OF THE APPOINTMENT IS APPRECIATED. <u>THIS OFFICE IS NOT RESPONSIBLE FOR OBTAINING OR CALLING FOR REFERRALS;</u>**
- **TO NOTIFY OUR SURGERY SCHEDULER AT SUN OF THE HOSPITAL REQUIRED BY THEIR INSURANCE, IF APPLICABLE, SO AS TO AVOID ADDITIONAL PATIENT FINANCIAL OBLIGATION FROM "OUT-OF-NETWORK" STATUS;**
- **TO MAKE SURE THAT DRS. SASLAWSKY, DANG, DONATO, FNP CRADDOCK AND FNP WILLIAMS ARE PARTICIPATING PHYSICIANS IN THE CURRENT INSURANCE PLAN, AND IF THE PLAN CHANGES TO VERIFY THEIR PARTICIPATION IN THE NEW INSURANCE COVERAGE;**
- **ANY REDUCTION OF PAYMENT BY THE INSURANCE COMPANY DUE TO FAILURE TO COMPLY WITH THE ABOVE INFORMATION WILL BECOME THE RESPONSIBILITY OF THE PATIENT. THIS OFFICE WILL NOT ASSUME ANY RESPONSIBILITY FOR VERIFYING PARTICIPATION OR SCHEDULING AT THE APPROPRIATE HOSPITAL;**
- **THE PATIENT WILL BE RESPONSIBLE FOR ANY COLLECTION FEES RESULTING FROM NON-PAYMENT OF ACCOUNTS.**

I HAVE READ THIS NOTICE AND UNDERSTAND MY RESPONSIBILITIES.

PATIENT/RESPONSIBLE PARTY SIGNATURE:___________________________________ DATE:________________________

HOSPITAL TO BE USED:____

REFERRING PHYSICIAN:____

INSURANCE AUTHORIZATION AND ASSIGNMENT

PRIMARY INSURANCE

YOUR RELATIONSHIP TO SUBSCRIBER: ___SELF ___SPOUSE ___CHILD PRIMARY CARD HOLDER:______________________________

INSURANCE COMPANY:__________________________ ID#_________________________ PATIENT ID#________________________

GROUP ID#____________________ PRIMARY CARD HOLDER DOB:___/___/_____ SEX: FEMALE MALE TRANSGENDER

PATIENT NAME:____

PRIMARY INSURANCE

YOUR RELATIONSHIP TO SUBSCRIBER: ___SELF ___SPOUSE ___CHILD PRIMARY CARD HOLDER:______________________________

INSURANCE COMPANY:__________________________ ID#_________________________ PATIENT ID#________________________

GROUP ID#____________________ PRIMARY CARD HOLDER DOB:___/___/_____ SEX: FEMALE MALE TRANSGENDER

PATIENT NAME:____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE MARK J. SASLAWSKY, M.D., GERALD T. DANG, M.D., ROBERT A. DONATO, M.D., ASHLEY CRADDOCK, FNP, BETHANY WILLIAMS, FNP OF SOUTHEAST UROLOGY NETWORK OR IT'S AGENTS TO FURNISH INFORMATION TO THE INSURANCE CARRIERS OR 3RD PARTY PAYORS CONCERNING MY MEDICAL CONDITION AND TREATMENT(S). I HEREBY ASSIGN TO THE ABOVE MENTIONED PHYSICIANS OF SOUTHEAST UROLOGY NETWORK OR ASSOCIATED UROLOGISTS OF MEMPHIS ALL PAYMENTS FOR MEDICAL SERVICES THEY RENDER TO ME AND/OR TO MY DEPENDENTS.

I UNDERSTAND THAT UNLESS OTHER ARRANGEMENTS ARE MADE BY EITHER ME OR MY INSURANCE COMPANY, I AM EXPECTED TO PAY AT THE TIME SERVICES ARE RENDERED. IN THOSE CASES WHERE PAYMENT IS NOT COLLECTED AT THE TIME OF SERVICE, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ANY AMOUNT NOT ALLOWED BY MY INSURANCE, EXCLUDING ANY PPO'S OR HMO'S IN WHICH I AUTHORIZE THE PHYSICIANS OF SOUTHEAST UROLOGY NETWORK OR ASSOCIATED UROLOGISTS OF MEMPHIS ARE PARTICIPATING PROVIDERS AND AGREE TO PAY ANY AND ALL AMOUNTS NOT PAID BY OTHERS WITHIN 30 DAYS FROM THE DATE BILLED. IN THE EVENT THAT ANY PAST DUE BALANCES NEED TO BE TURNED OVER TO COLLECTIONS, I AGREE TO PAY ALL COLLECTION COSTS INCLUDING, BUT NOT LIMITED TO, COURT COSTS, WITNESS EXPENSE AND REASONABLE ATTORNEY FEES.

ADULT PATIENT/GUARANTOR SIGNATURE:____ DATE:____________________

MEDICARE CERTIFICATION

I HEREBY AUTHORIZE MARK J. SASLAWSKY, M.D., GERALD T. DANG, M.D., ROBERT A. DONATO, M.D., ASHLEY CRADDOCK, FNP, BETHANY WILLIAMS, FNP OF SOUTHEAST UROLOGY NETWORK TO FILE CLAIMS ON MY BEHALF WITH MEDICARE, MY INSURANCE CARRIER, AND MY SECONDARY INSURANCE.

I HEREBY AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, IT'S INTERMEDIARIES OR CARRIERS, AND INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN LIEU OF THE ORIGINAL AND REQUEST PAYMENTS OF MEDICAL INSURANCE BENEFITS TO BE MADE TO THE PHYSICIANS OF SOUTHEAST UROLOGY NETWORK OR THE PHYSICIANS OF ASSOCIATED UROLOGISTS OF MEMPHIS FOR SERVICES PROVIDED TO ME AND/OR MY DEPENDENTS.

I UNDERSTAND THAT IF SUCH MEDICAL OR SURGICAL SERVICES ARE ULTIMATELY APPROVED AND DETERMINED BY MEDICARE TO BE "MEDICALLY NECESSARY" UNDER SECTION 1862(S) (1) OF THE MEDICARE LAW, IT WILL PAY ONLY 80% OF WHAT MEDICARE ALLOWS FOR THESE SERVICES. IT IS MY RESPONSIBILITY TO PAY THE REMAINING 20% BALANCE. UNDER FEDERAL LAW, A PHYSICIAN MUST COLLECT THIS 20% COINSURANCE BALANCE.

I ACKNOWLEDGE THAT I HAVE BEEN FULLY NOTIFIED BY MY PHYSICIAN THAT MEDICARE MAY DENY PAYMENT FOR ALL OR PART OF THESE SERVICES TO ME, OR MY DEPENDENTS IF THEY DETERMINE THEM NOT TO BE "MEDICALLY NECESSARY." IF MEDICARE DENIES PAYMENT FOR THESE SERVICES, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR THEIR PROMPT PAYMENT. IN THE EVENT THAT ANY PAST DUE BALANCES NEED TO BE TURNED OVER FOR COLLECTIONS, I AGREE TO PAY ALL COLLECTION COSTS INCLUDING, BUT NOT LIMITED TO, COURT COSTS, WITNESS EXPENSE, AND REASONABLE ATTORNEY FEES.

ADULT PATIENT/GUARANTOR SIGNATURE:____ DATE:____________________

SOUTHEAST UROLOGY NETWORK

PLEASE FILL OUT AS COMPLETELY AS POSSIBLE!

REASON FOR TODAY'S VISIT: ______________________________

IF IT'S YOUR FIRST VISIT, WERE YOU REFERRED BY A DOCTOR/NURSE PRACTITIONER? ❍Y ❍N

IF YES, WHO REFERRED YOU? ______________________________

PAST MEDICAL HISTORY

PLEASE CHECK IF YOU HAVE EITHER HAD THE CONDITION, IT IS CURRENTLY PRESENT OR IT IS BEING TREATED.

❍ HIGH BLOOD PRESSURE	❍ DIABETES (HIGH SUGARS)
❍ HEART DISEASE	❍ STROKE, MINI-STROKE
❍ CANCER; IF YES, WHAT KIND?	
❍ KIDNEY STONES	❍ POOR KIDNEY FUNCTION
❍ GLAUCOMA	❍ GOUT
❍ LUMBAR DISC DISEASE/LOW BACK PAIN/SPINAL PROBLEMS/SPINAL INJURY	
❍ SLEEP APNEA; IF YES, USING A CPAP MACHINE AT HOME? ❍ Y ❍ N	

PAST SURGICAL HISTORY

PLEASE CHECK IF YOU HAVE HAD THE FOLLOWING REMOVED, REPAIRED OR OPERATED ON. PLEASE INCLUDE ALL SURGERIES AND LIST THE DATE BESIDE ANY CHECKED ITEM.

❍ APPENDIX	❍ TONSILS & ADENOIDS
❍ HERNIA (ANY)	❍ GALLBLADDER
❍ CANCER SURGERY; IF YES, WHAT KIND?	
❍ BACK SURGERY; IF YES, WHAT LEVEL(S)?	
❍ INTESTINAL EXPLORATION/REMOVAL	❍ HIP OR KNEE REPLACED
❍ HEART BYPASS/VALVE	❍ LAP BAND/STOMACH STAPLE
❍ KIDNEY STONES; IF YES, WHICH?❍ LITHO/"SHOCK"❍ SCOPE/"LASER"❍ PCNL/"BACK"	

FOR MEN:	❍ PROSTATE	❍ TESTICLE	❍ PENIS	❍ SCROTUM

FOR WOMEN:	❍ BLADDER/URETHRA SUSPENSION	❍ HYSTERECTOMY
	❍ PREGNANCIES/BIRTHS ___/___	❍ PELVIC FLOOR SURGERY

OTHER IMPORTANT INFORMATION: SURGERIES/HOSPITALIZATIONS

HEREDITARY/GENETIC TESTING INFORMATION

HAVE YOU OR ANYONE IN YOUR FAMILY COMPLETED CANCER-RELATED GENETIC TESTING? ● Y ● N

IF YES, DO YOU HAVE ACCESS TO THE RESULTS? ● Y ● N RESULTS:______________________________

FAMILY/SOCIAL/SEXUAL HISTORY

PLEASE ANSWER THE FOLLOWING COMPLETELY. FOR FAMILY HISTORY, PLEASE INDICATE WHO HAS BEEN AFFECTED BY THE INDICATED DISEASE. NOTE THAT THESE ANSWERS ARE CONFIDENTIAL.

FAMILY (CIRCLE M FOR MOTHER, F FOR FATHER, S FOR BROTHER/SISTER, GP FOR GRANDPARENT)

❍ HIGH BLOOD PRESSURE	M	F	S	GP	❍ DIABETES	M	F	S	GP
❍ HEART DISEASE	M	F	S	GP	❍ LUNG DISEASE	M	F	S	GP
❍ KIDNEY STONES	M	F	S	GP	❍ KIDNEY FAILURE	M	F	S	GP
❍ CANCER (TYPE:___________)	M	F	S	GP	❍ OTHER:	M	F	S	GP
❍ CANCER (TYPE:___________)	M	F	S	GP	❍ CANCER (TYPE:___________)	M	F	S	GP

SOCIAL/SEXUAL

USE TOBACCO ❍ Y ❍ N **IF YES:** ❍ SMOKE PK/DAY ❍ CHEW/DIP ❍ CIGAR/PIPE

❍ PREVIOUS TOBACCO USE ❍ SMOKED PK/DAY QUIT YEARS AGO

USE CAFFEINE (COFFEE,TEA,SODA) ❍ NONE ❍< 2 ❍ MORE THAN 2 CUPS|CANS|GLASSES/DAY

MEDICATION ALLERGY(IES) ❍ Y ❍ N **IF YES, ANY LIFE THREATENING?** ❍ Y ❍ N

EXERCISE DAILY ❍ Y ❍ N **IF YES** ❍ < 10 MINS ❍ 10-30 MINS ❍ > 30 MINS

ALCOHOL USE ❍ Y ❍ N **IF YES** ❍ RARE ❍ < 5 /WEEK ❍ 1-2 DAILY ❍ MORE THAN 2/DAY

DRUG USE ❍ Y ❍ N **IF YES** ❍ RARE ❍ MONTHLY ❍ WEEKLY ❍ DAILY

SEXUALLY ACTIVE ❍ Y ❍ N **IF YES** ❍ MONTHLY OR LESS ❍ WEEKLY ❍ DAILY |❍ > 1 PARTNER

OCCUPATION: |IF RETIRED, PREVIOUS WORK:

MEDICATION NAME (PLEASE LIST **ALL** MEDICATIONS TAKEN, INCLUDING OVER THE COUNTER DRUGS)	**DOSAGE** (USUALLY IN MGS)	**HOW OFTEN?** (ONCE A DAY ETC.)

PREFERRED PHARMACY: ______________________ **CITY:** ______________

INTERSECTION: ____

DRUG ALLERGIES (INCLUDING LATEX)	**REACTION**	**LIFE THREATENING?**

SOUTHEAST UROLOGY NETWORK

REVIEW OF SYSTEMS			
PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THESE SYMPTOMS RECENTLY. IF YOU HAVE NOT, PLEASE CHECK NO.			
URINARY RETENTION	● Y ● N	HOME OXYGEN	● Y ● N
PAIN ON URINATION	● Y ● N	COUGH	● Y ● N
FREQUENT URINATION	● Y ● N	BLOOD IN SPUTUM	● Y ● N
FEVER	● Y ● N	EASY BLEEDING	● Y ● N
CHILLS	● Y ● N	SWOLLEN GLANDS	● Y ● N
FATIGUE	● Y ● N	ANEMIA	● Y ● N
RASHES	● Y ● N	EYE PAIN	● Y ● N
BOILS/PUS	● Y ● N	BLURRY VISION	● Y ● N
ITCHING	● Y ● N	DOUBLE VISION	● Y ● N
UNHAPPY WITH LIFE	● Y ● N	DIZZINESS	● Y ● N
DEPRESSION	● Y ● N	TREMORS	● Y ● N
SUICIDAL THOUGHTS	● Y ● N	NUMBNESS	● Y ● N
EAR INFECTION	● Y ● N	WEAKNESS	● Y ● N
SORE THROAT	● Y ● N	HEADACHE	● Y ● N
SINUS PROBLEMS	● Y ● N	LEG SWELLING	● Y ● N
SEX DRIVE	● Y ● N	VARICOSE VEINS	● Y ● N
FERTILITY	● Y ● N	CHEST PAIN	● Y ● N
ABDOMINAL PAIN	● Y ● N	IRREGULAR BEATS	● Y ● N
NAUSEA/VOMITING	● Y ● N	NECK PAIN	● Y ● N
HEART BURN	● Y ● N	JOINT PAIN	● Y ● N
BLOOD IN STOOL	● Y ● N	BACK PAIN	● Y ● N
CONSTIPATION	● Y ● N	EXCESSIVE THIRST	● Y ● N
SHORT OF BREATH	● Y ● N	TOO HOT/COLD	● Y ● N
WHEEZING	● Y ● N	TIRED/SLUGGISH	● Y ● N
WOMEN ONLY		**MEN ONLY**	
PELVIC ORGAN PROLAPSE	● Y ● N	ERECTIONS	● Y ● N
PELVIC PAIN	● Y ● N	EJACULATIONS	● Y ● N

I CERTIFY THAT THE ABOVE INFORMATION, TO THE BEST OF MY ABILITY, HAS BEEN FILLED OUT TRUTHFULLY AND COMPLETELY.

PATIENT SIGNATURE:____________________________________ **DATE:**________________