UCPA
UROLOGY
OF CENTRAL PA, INC.

PATIENT INFORMATION

LAST NAME:_____ FIRST:_____ MIDDLE:_____

SOCIAL SECURITY NO:_____ DATE OF BIRTH:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

HOME PHONE#_____ CELL PHONE#_____

WORK PHONE#_____ EMAIL ADDRESS:_____

OCCUPATION:_____ EMPLOYER:_____

RACE:

	White		Black/African American
	Asian		American Indian/Alaska Native
	Other		Native Hawaiian/Other Pacific Islander

ETHNICITY:

	Spanish/Hispanic Origin
	Not of Spanish/Hispanic Origin

PREFERRED LANGUAGE: ENGLISH SPANISH OTHER_____

SPOUSE'S NAME:_____

SPOUSE'S WORK PHONE#_____ SPOUSE'S CELL PHONE#_____

If patient is child, Responsible Party:_____

FAMILY PHYSICIAN:_____

WHO WERE YOU REFERRED BY:_____

PRIMARY INSURANCE:_____

POLICY HOLDER:_____ BIRTH DATE:_____

INSURANCE ID#_____ GROUP#_____

SECONDARY INSURANCE:_____

POLICY HOLDER:_____ BIRTH DATE:_____

INSURANCE ID#_____ GROUP#_____

PATIENT HISTORY

Today's Date _____

THE FOLLOWING INFORMATION IS VERY IMPORTANT TO YOUR HEALTH. PLEASE TAKE TIME TO FULLY AND COMPLETELY FILL OUT THIS IMPORTANT INFORMATION. WE ARE COUNTING ON YOU.

Last Name_____ First Name_____ MI _____ DOB ____/____/_____

List All Allergies to Medications (including iodine and shellfish allergies)_____

Have you ever had any problems with Anesthesia? Yes No

If yes, please explain_____

Past Medical History (Circle those that apply to you and list all other health problems)

Asthma	Heart Disease	Implanted Pacemaker	Previous Transfusions
Cancer (_____)	Hepatitis (Type ____)	Kidney Failure	Thyroid Problems
Diabetes	High Blood Pressure	Kidney Stones	Tuberculosis
Depression	High Cholesterol	Mitral Valve Prolapse	
Emphysema	H.I.V. / A.I.D.S.	Multiple Sclerosis	
Glaucoma	Implanted Defibrillator	Parkinson's Disease	

Other Illnesses:

_____ _____ _____

_____ _____ _____

Do you use a ventilation device such as CPAP or BiPAP ? (Please circle) Yes No

Do you require Antibiotics to be given routinely before procedures? (please circle) Yes No

If yes, reason why?_____

Antibiotics and Doses taken_____

Past Surgical History (List all of your prior operations, dates performed and reason for them)

_____ Date	_____ Date	_____ Date
_____ Date	_____ Date	_____ Date
_____ Date	_____ Date	_____ Date

Social History

Occupation_____ Marital Status_____ # of Children_____

Do you currently use tobacco, cigarettes or pipes? Yes No If yes, how much per day? _____

Have you used tobacco products in the past? Yes No If yes, how many years? _____

Do you use alcohol? Yes No If yes, how often and how much_____

Reviewing Physician's Signature

_____ Date	_____ Date	_____ Date
_____ Date	_____ Date	_____ Date

Family History (circle answer and list the family member's relationship to you)

Has anyone had prostate cancer?	Yes	No	Who?_____
Has anyone had bladder cancer?	Yes	No	Who?_____
Has anyone had kidney cancer?	Yes	No	Who?_____
Has anyone had kidney stones?	Yes	No	Who?_____

List any other immediate family member's serious illnesses_____

_____

_____

Review of Systems (Do you have any recent problems with the following systems? Circle answer)

Constitutional:	Fever	Yes	No	Weight Loss	Yes	No
Integumentary:	Skin Rash	Yes	No	Persistent Skin Itch	Yes	No
Eyes:	Blurred Vision	Yes	No	Eye Pain	Yes	No
Ear/Nose/Throat:	Sinus Problems	Yes	No	Ear Infections	Yes	No
Respiratory:	Short of Breath	Yes	No	Wheezing	Yes	No
Cardiovascular:	Chest Pain	Yes	No	Varicose Veins	Yes	No
Gastrointestinal:	Vomiting	Yes	No	Diarrhea	Yes	No
Musculoskeletal:	Back Pain	Yes	No	Joint Pain	Yes	No
Genitourinary:	Urine Retention	Yes	No	Painful Urination	Yes	No
Neurological:	Dizzy Spells	Yes	No	Numbness/Tingling	Yes	No
Hematologic/Lymphatic:	Swollen Glands	Yes	No	Anemia	Yes	No
Endocrine:	Excessive Thirst	Yes	No	Excessive Fatigue	Yes	No
Allergy/Immunologic:	Hay Fever	Yes	No	Trouble Clearing Infection	Yes	No
Gynecological:	Uterine Fibroids	Yes	No	Pelvic Pain	Yes	No

Date of Last Menstrual Period _____/_____/_____

Psychiatric:	Are you satisfied with your life?	Yes	No
	Do you feel severely depressed?	Yes	No

List any other problems and explain any yes answers_____

_____

_____

Patient or POA/Guardian Statement:

I certify that the information provided on the Patient History Form is accurate and complete.
I attest that the patient's entire medical and surgical history has been listed.

Patient/POA Signature_____ Today's Date _____

MEDICATION LIST

Patient Full Name_____ Date of Birth_____/_____/_____

Patient Daytime Contact Number_____ Social Security #_____

Pharmacy Name_____ Pharmacy Phone Number_____

Medication Allergies (including shellfish)_____

Date	Medication Name	Dose	How Much and How Often Taken	D / C Date (office use)

Reviewed by _____ Date_____ Reviewed by _____ Date_____

Reviewed by _____ Date_____ Reviewed by _____ Date_____

Reviewed by _____ Date_____ Reviewed by _____ Date_____

Reviewed by _____ Date_____ Reviewed by _____ Date_____

FINANCIAL POLICY

Urology of Central Pennsylvania is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

****PAYMENT OF COPAYS, DEDUCTIBLES AND NON-COVERED AMOUNTS IS DUE AT THE TIME OF SERVICE. We accept Cash, Checks, Visa, Mastercard, Discover, American Express and CareCredit.****

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We will bill your insurance carrier according to our agreement with them based on the insurance information you have provided to us. We file insurance claims as a courtesy to you. We will not become involved in disputes between you and your insurance company regarding deductibles, copays, referrals, covered & non-covered services, secondary insurance, etc. other than to supply factual information as necessary.

Urology of Central Pennsylvania's CT scan, ultrasound, radiation therapy, clinical laboratory and pathology services are owned and operated by UCPA for the benefit of our patients. If your UCPA physician concludes that CT scan, clinical laboratory, pathology, radiation therapy or ultrasound services are medically necessary because of your condition, you may have your CT scan, radiation therapy, ultrasound, clinical laboratory or pathology performed at UCPA, or at any other facility, if you choose to do so.

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THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY.
PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS,
OUR BILLING DEPARTMENT WILL BE HAPPY TO HELP YOU.

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YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT

I understand that I am financially responsible for all co-payments, deductibles, co-insurance and all amounts my insurance does not cover. In the event I fail or refuse to submit timely payment for all co-payments, deductibles, co-insurance and amounts any commercial or government third party payer does not cover, I agree to pay 30% of said outstanding amount as a collection fee. I intend to be legally bound hereby.

I also understand that if I fail to keep my scheduled appointments, I may be charged an unkept office visit fee of $30.00.

I request that payment of authorized medical benefits, including Medicare benefits be made either to me or on my behalf to Urology of Central Pennsylvania for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents, my insurance company or its intermediaries, this physician's office or other physician's offices any information needed to determine these benefits or benefits payable for related services or as may be needed for my medical care. I permit a copy of this authorization to be used in place of the original.

Signature_____ Date_____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Urology of Central Pennsylvania for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.

Signature_____ Date_____

Revised March 2014