Patient Registration Form (eCW)

PATIENT INFORMATION **(Please Print)**

❑ Dr. ❑ Miss ❑ Mr. ❑Mrs. ❑Ms. ❑Sir ❑Jr. ❑Sr. ❑Other_____

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Mailing Address _____ Physical Address _____

City, State, ZIP (+4) _____ City, State, ZIP (+4) _____

Phone Numbers Work _____ ❑Day ❑Evening Home _____ ❑Day ❑Evening

Cellular _____ Pager _____

Primary Care Provider (PCP) _____ Referring Physician _____

Date of Birth (MM/DD/YYYY) _____ Sex ❑ Male ❑ Female ❑ Transgender

Marital Status ❑Married ❑Single ❑Divorced ❑Widowed ❑Legally Separated ❑Partner

Social Security Number _____-_____-_____ E-mail Address _____

Employment Status ❑ 1- Full-Time ❑ 2- Part-Time ❑ 3-Not Employed ❑4- Self-Employed ❑ 5-Retired ❑ 6-Active Military

Student Status ❑ 1- Full-Time Student ❑ 2- Part-Time Student ❑ N- Not a Student

Race _____ Ethnicity _____ Language _____

EMERGENCY CONTACT INFORMATION **(information used for emergencies only)**

Emergency Contact Name _____ Phone Number _____

Emergency Contact Relationship to Patient _____ ❑ Guardian

Address _____ City; State; Zip (+4):_____

RESPONSIBLE PARTY INFORMATION **(information used for patient balance statements)**

Responsible Party ❑ Another Patient ❑ Guarantor ❑ Self **Check here if information is same as patient ❑**

Responsible Party Name (Last)_____ (First)_____ (MI)_____

Guarantor Account # _____ Date of Birth (MM/DD/YYYY) _____ ❑ Male ❑ Female

Social Security Number _____-_____-_____ Phone #(s) _____

E-Mail Address _____

Mailing Address _____ Physical Address _____

City, State, ZIP (+4)_____ City, State, ZIP (+4)_____

Employer_____ Employer Phone Number_____

Patient Relationship to Responsible Party_____

PRIMARY INSURANCE INFORMATION **(provide your insurance card(s) to the front desk at check-in)**

Insurance Company/Phone Number _____ ( ) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____Group ID _____Copay Amount _____

Effective Date_____ Termination Date_____

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

SECONDARY INSURANCE INFORMATION **(provide your insurance card(s) to the front desk at check-in)**

Insurance Company/Phone Number _____ ( ) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____Group ID _____Copay Amount _____

Effective Date_____ Termination Date_____

Insured Date of Birth_____/_____/_____ Insured's Social Security Number _____-_____-_____

PRIMARY PHARMACY INFORMATION **(provide your primary pharmacy to the front desk at check-in)**

Pharmacy Name/Phone Number _____ ( ) _____

Address_____ City; State; Zip (+4) _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

PATIENT HISTORY FORM

NOTE: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Date: _____

Patient Name: _____ **DOB:** _____ **Chart #:** _____

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

_____

Genitourinary Symptoms

Frequency of urination (how many times do you make water)		Day _____	Night _____
Inability to urinate (urinary retention)		❑Yes	❑No
When voiding, do you feel you empty your bladder completely		❑Yes	❑No
Burning with urination		❑Yes	❑No
	If yes, when?	❑Constant	❑Before ❑During ❑After
Feel the need to urinate but unable or only a small amount at a time		❑Yes	❑No
Leaking of urine under stressful conditions (i.e. cough, exercise, etc.)		❑Yes	❑No
	If yes, do you wear pads/diaper?	❑Yes	❑No How many used per day _____
Do you need to strain to urinate		❑Yes	❑No
Dribbling small amounts of urine even when the bladder is empty		❑Yes	❑No
Hesitancy (waiting a long time to pass urine)		❑Yes	❑No
Blood in the urine		❑Yes	❑No
Flank pain (pain in the area of the kidneys, mid to lower back)		❑Yes	❑No
Flank pain that radiates to the groin		❑Yes	❑No
Male	Pain/swelling in the penis	❑Yes	❑No
	Pain/swelling in the testicles	❑Yes	❑No
	Pain/swelling between the penis and testicles	❑Yes	❑No
	Erectile dysfunction	❑Yes	❑No
Female	Vaginal discharge	❑Yes	❑No If yes, what color? _____
	Dropped bladder	❑Yes	❑No
	If yes, did your physician tell you this?	❑Yes	❑No
Constipation		❑Yes	❑No
Diarrhea		❑Yes	❑No

History of Present Illness

Please answer the following questions:

Where is the problem located?
❑Abdomen ❑Leg
❑Flank area(mid to lower back) ❑Groin
Other _____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
❑2 days ago ❑2 weeks ago ❑1 month ago
Other _____

Does anything help or make the problem worse?
❑Moving around ❑Standing up ❑Lying on my side
Other _____

How long does the problem last?
❑30 minutes ❑1 hour ❑ It is always there

Other _____

Is anything else occurring at the same time?
❑Yes ❑No
If yes – ❑Nausea ❑Rash ❑Headaches
Other _____

Is the problem- ❑Constant ❑Off and on
❑Sharp then dull ❑Very sharp then leaves ❑Always there
Other _____

Does the problem interfere with your normal functions?
❑Yes ❑No
If yes, please explain _____
_____

Continued/over…..

PAST MEDICAL HISTORY

Stomach Disease	❑No	❑Yes
Ulcer	❑No	❑Yes
Diverticulitis	❑No	❑Yes
High Blood Pressure	❑No	❑Yes
Heart Attack	❑No	❑Yes
High Cholesterol	❑No	❑Yes
Stroke	❑No	❑Yes
Diabetes (Sugar)	❑No	❑Yes
Asthma	❑No	❑Yes
Bronchitis	❑No	❑Yes
Emphysema	❑No	❑Yes
Black Lung	❑No	❑Yes
Liver Disease	❑No	❑Yes
Blood clotting problems	❑No	❑Yes
Kidney Disease	❑No	❑Yes
Kidney Stone	❑No	❑Yes
Venereal Disease	❑No	❑Yes
Aids/HIV	❑No	❑Yes
Convulsions	❑No	❑Yes
Arthritis/Gout	❑No	❑Yes
Back Trouble	❑No	❑Yes
Cancer	❑No	❑Yes

Previous Hospitalizations/Surgeries/Serious Illness When?

_____

_____

_____

Are you on medications? ❑Yes ❑No If yes, which ones/how often?

_____

_____

_____

Do you take any of the following:

Aspirin ❑Yes ❑No How much/how often?_____

Coumadin (warfarin) ❑Yes ❑No How much/how often?_____

Plavix (clopidogrel) ❑Yes ❑No How much/how often?_____

Lovenox (enoxaparin) ❑Yes ❑No How much/how often?_____

Do you take anything else that makes your blood thinner? _____

Are you allergic to any medications? ❑Yes ❑No If yes, which ones?

_____

Do you have any seasonal allergies? ❑Yes ❑No

(i.e. pollens, grass, tress, cat/dog, etc.)

SOCIAL HISTORY:

Marital Status: ❑Single ❑Married ❑ Separated ❑Divorced ❑Widowed

Use of Alcohol: ❑Never ❑Rarely ❑Moderate ❑Daily

Use of Tobacco:

Cigarettes	❑No	❑Yes	If yes, how much do you use in a day's time? _____
Smokeless Tobacco	❑No	❑Yes	If yes, what type do you use and how much in a day's time? _____

Use of Illicit Drugs:

Current	❑No	❑Yes	If yes, what type and how often? _____
Past	❑No	❑Yes	If yes, what type and how often? _____

Excessive exposure at home or work to: ❑Fumes ❑Dust ❑Solvents ❑Airborne particles

Spicy foods	❑Yes	❑No	
Soda	❑Yes	❑No	If yes, how much? _____
Coffee	❑Yes	❑No	If yes, how much? _____
Tea	❑Yes	❑No	If yes, how much? _____

FAMILY MEDICAL HISTORY

Diabetes	❑Yes	❑No	Lung Cancer	❑Yes	❑No
Tuberculosis	❑Yes	❑No	Kidney Disease	❑Yes	❑No
Heart Disease	❑Yes	❑No	Heart Attack	❑Yes	❑No
Liver Disease	❑Yes	❑No	Colon Cancer	❑Yes	❑No
Prostate Cancer	❑Yes	❑No	Stroke	❑Yes	❑No
Bladder Cancer	❑Yes	❑No	High Blood Pressure	❑Yes	❑No
Breast Cancer	❑Yes	❑No	Kidney Cancer	❑Yes	❑No

Other _____

REVIEW OF SYSTEMS

Do you now have or have had any problems related to the following systems? Check Yes or No. Please explain any that you answer "Yes" in the space provided.

Constitutional Symptoms

Fever	❑Y	❑N
Chills	❑Y	❑N
Headache	❑Y	❑N

Other _____

Eyes

Blurred vision	❑Y	❑N
Double vision	❑Y	❑N
Pain	❑Y	❑N

Other _____

Allergic/Immunologic

Hay fever	❑Y	❑N
Drug Allergies	❑Y	❑N

Other _____

Musculoskeletal

Joint pain	❑Y	❑N
Neck pain	❑Y	❑N
Back pain	❑Y	❑N

Other _____

Neurological

Tremors	❑Y	❑N
Dizzy spells	❑Y	❑N
Numbness and tingling	❑Y	❑N

Other _____

Ears/Nose/Throat/Mouth

Ear infections	❑Y	❑N
Sore throats	❑Y	❑N
Sinus problems	❑Y	❑N

Other _____

Endocrine

Too hot/cold	❑Y	❑N
Excessive thirst	❑Y	❑N
Tired/sluggish	❑Y	❑N

Other _____

Respiratory

Wheezing	❑Y	❑N
Frequent cough	❑Y	❑N
Shortness of breath	❑Y	❑N

Other _____

Gastrointestinal

Nausea/vomiting	❑Y	❑N
Indigestion/heartburn	❑Y	❑N
Hiatal hernia	❑Y	❑N

Other _____

Psychologic

Memory loss and confusion	❑Y	❑N
Nervousness	❑Y	❑N
Depression	❑Y	❑N

Other _____

Hematologic/Lymphatic

Swollen glands	❑Y	❑N
Blood clotting problems	❑Y	❑N
Are you taking blood thinners at the present time?	❑Y	❑N

Other _____

Integumentary

Skin rash	❑Y	❑N
Boils	❑Y	❑N
Persistent itch	❑Y	❑N

Other _____

Cardiovascular

Chest pain	❑Y	❑N
Varicose veins	❑Y	❑N
High blood pressure	❑Y	❑N

Other _____

_____ _____

Signature of Patient, Parent or Guardian **Date**

_____ _____

Signature of Doctor **Date**

PELVIC PAIN and URGENCY/FREQUENCY
PATIENT SYMPTOM SCALE

Please check the answer below that best describes how you feel for each question.

	0	1	2	3	4
1. How many times do you go to the bathroom during the day?	3-6 ❑	7-10 ❑	11-14 ❑	15-19 ❑	20+ ❑
2. How many times do you go to the bathroom at night?	0 ❑	1 ❑	2 ❑	3 ❑	4+ ❑
3. Are you currently sexually active? ❑Yes ❑No					
4. a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never ❑	Mildly ❑	Moderate ❑	Severe ❑	
b. If you have pain, does it make you avoid sexual intercourse?	Never ❑	Occasionally ❑	Usually ❑	Always ❑	
5. Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes or scrotum)?	Never ❑	Occasionally ❑	Usually ❑	Always ❑	
6. Do you have urgency after going to the bathroom?	Never ❑	Occasionally ❑	Usually ❑	Always ❑	
7. a. If you have pain, is it usually…		Mild ❑	Moderate ❑	Severe ❑	
b. Does your pain bother you?	Never ❑	Occasionally ❑	Usually ❑	Always ❑	
8. a. If you have urgency, is it usually…		Mild ❑	Moderate ❑	Severe ❑	
b. Does your urgency bother you?	Never ❑	Occasionally ❑	Usually ❑	Always ❑	

Symptom Score = _____
(1, 2a, 4a, 5, 6, 7a, 8a)

Bothersome Score = _____
(2b, 4b, 7b, 8b)

Total Score = _____
(Symptom Score + Bothersome Score)

AUA SYMPTOM SCORE (AUASS)

PATIENT NAME: _____ **TODAY'S DATE:** _____

(Check One Number on Each Line)	Not at All	Less Than 1 Time in 5	LessThan Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0 ❑	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
During the past 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 ❑
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0 ❑	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
During the past month or so, how often have you found it difficult to postpone urination?	0 ❑	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
During the past month or so, how often have you had a weak urinary stream?	0 ❑	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
During the past month or so, how often have you had to push or strain to begin urination?	0 ❑	1 ❑	2 ❑	3 ❑	4 ❑	5 ❑
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**
Over the past month, how many times per night 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 the score for each number above and write the total in the space to the right. **TOTAL:** _____

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	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 ❑

CLINCH VALLEY UROLOGY

LAWRENCE W. BENDER, D.O.

6719 Gov. G. C. Peery Highway, Suite 1800

Richlands, VA 24641

Office 276-596-6659 **Fax 276-596-6658**

May Clinch Valley Urology – Dr. Bender and/or members of the office staff release medical information to specified person other than you? ❑Yes ❑No

If yes, please specify to whom this information may be released.

Authorized Person	**Relationship to You**
_____	_____
_____	_____
_____	_____

What information may be released?

Lab Results	❑Yes	❑ No___
X-ray reports	❑Yes	❑No___
Medications	❑Yes	❑No___
Medical status	❑Yes	❑No___
Appointments	❑Yes	❑No___

I understand that as part of my continuing healthcare, my physician maintains records in his/her office, which contain my health history, symptoms, examinations test results, diagnoses and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premise a copy of the "Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosure of my medical record, and that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me on request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

_____ _____

Patient Signature Date

LifePoint Physician Services

Clinch Valley Urology

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments.
- Administration of any needed anesthetics.
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed medication.
- Performance of diagnostic procedures/tests and cultures.
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Clinch Valley Urology may include consent at satellite offices under common ownership.

I, the undersigned, authorize Clinch Valley Urology to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Clinch Valley Urology.

I acknowledge that I have been given the Clinch Valley Urology Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature ***Date***