Middlesex Health
Urology

Dear Patient,

Everyone at Middlesex Health Urology is excited to welcome you into our family of patients. As one of the area's leading health care providers, we look forward to meeting all of your urological care needs now and in the future.

We have enclosed patient information forms for you to fill out. On the date of your scheduled appointment, please arrive 15 minutes early to complete paperwork and registration. Please bring these forms with your insurance card, a complete list of medication, a photo ID and copay at the time of your visit. A $10.00 administrative fee will be charged if not paid at time of service.

If your insurance requires a referral, please contact your primary care office or insurance carrier for one before the appointment.

If you are unable to make your appointment for any reason, please give us 24 hours' notice by calling 860-347-8850 to cancel or reschedule. A $50.00 fee will be charged for insufficient cancelation notice or missed appointments.

Sincerely,

Your Team at Middlesex Urology

410 Saybrook Rd, Lower Level, Middletown, CT 06457
860-347-8850

Middlesex Health Urology New Patient and Returning New Patient Form

Patient Name:	**DOB:**	**Date:**
PT Sex: Male Female M/F F/M		
Mailing Address:		
Email Address:		
Marital Status □ Single □ Married □ Divorced □ Widowed □ Partner □ Other		
Social Security:	**Ethnicity:**	
Home Phone:	**Work Phone:**	**Cell Phone:**
Emergency Contact:		
Name:	**Phone:**	**Relation:**
Preferred Communication and Portal Access: Please circle preferences		
Please select one voice option:	**Home# Cell# Work#**	
Select all that applies:	**Text Email**	
Patient's Employer Information		
Employer Name:	**Occupation:**	
Address:	**Phone:**	
If Student □ Full time □ Part time	**School:**	
Insurance Information- Primary/Secondary/ Other	**Do you have health insurance? Yes No**	
Primary Insurance:	**ID#:**	
Secondary Insurance:	**ID#:**	
Physician:	**Physician's address:**	
Pharmacy:	**Pharmacy Address:**	

Name: **DOB**

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to Middlesex Health Urology, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Middlesex Health Urology will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as all costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Middlesex Health Urology, its successors and assigns or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance Information within my health plan's riling limit for services rendered.

Medicare Authorizations for Treatment, Payment & Healthcare Operations. Medicare Recipients Sign both Authorizations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Middlesex Health Urology for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

_____

Patient's Signature **Date**

Name: _____ **DOB:**_____

What is the reason for your visit today? _____

_____

Height: ___'___ **Weight:** _____

Have you ever been diagnosed with any of the following? (Please circle)

Diabetes/type _____	Kidney stones	COPD	Arrhythmia	Hepatitis A, B, C,
Ulcer	Recurring UTI	Venous thrombosis	Hypertension	Anemia
Arthritis	Prostatitis	Pulmonary embolism	Diverticulitis	Thyroid: hyper/hypo
Cancer/type _____	Stroke	Coronary artery disease	Seizure	High cholesterol
Kidney disease	Asthma	Heart failure	Depression	GERD

Surgeries

Colon	Appendix	Stone	Ovarian
Gallbladder	Lung	Bladder	Uterine
Hernia	Joint Replacement	Prostate	Breast
Tonsillectomy	Heart	Testis	C-Section
Cataract	Kidney	Vasectomy	Other _____

Has anyone in your family been diagnosed with the following? (Please identify who in the space below)

Prostate Cancer _____	Bladder Cancer _____	Kidney Cancer _____	Bladder Cancer _____	Diabetes _____	Hypertension _____
Breast Cancer _____	Testis Cancer _____	Colon Cancer _____	Heart Disease _____	Stroke _____	Kidney Stones _____

Social History

Marital Status: _____ Are you a smoker? _____How much do you smoke? ____ Have you ever been a smoker? ____

How long did you smoke for? ____ When did you quit? ____ Do you drink alcohol? ____ How often? ____

Do you drink coffee/tea? ____ Cups per day: ____ Do you drink soda? ____ Cups per day: ____

Did you get a Flu Shot? ____ Date: ___/___/___ If you are over 60, have you received the Pneumonia Vaccine? ____

Please use the back of this page for any additional information that is not listed on this form

Name:_____ **DOB:** _____

Urinary ROS

Blood in urine	Smaller stream	Testicular pain	Impotent
Urinary frequency	Urgency	Incontinence	Unable to obtain erection
Nocturia Urinating ___ times at night	Painful urination	Normal period	Unable to maintain erection
Urinary hesitancy	Testicular lump	Menopause	Other urinary symptoms: _____

ROS

Weight change	Neck pain	Diarrhea	Wheezing	Motor disturbances
Chills	Neck stiffness	Itching	Chest pain or discomfort	Sensory disturbances
Fever	Lump or swelling in neck	Skin lesion	Fast heart rate	Easy bleeding
Night sweats	Difficulty swallowing	Skin rash	Palpitations	Easy bruising
Feeling tired or poorly	Heartburn	Shortness of breath	Excessive sweating	Sleep disturbances
Headache	Nausea	Cough	Excessive thirst	Anxiety
Eyesight problems	Vomiting	Coughing up blood	Dizziness	Depression
Nosebleeds	Abdominal pain	Night sweats	Spinning dizziness (vertigo)	Other: _____

Please use the back of this page for any additional information that is not listed on this form

Name:_____ **DOB:**_____

Medication	**Dosage**

Medication Allergies:

Middlesex Health Urology HIPAA Privacy Authorization Form

Name:_____ **DOB:**_____

Consent for Treatment:

Permission is hereby given to the physicians and staff of Middlesex Health Urology to provide ordinary and necessary medical examination, diagnosis, and treatment, and administer such therapeutic treatment of services that the physician may order. Ordinary and necessary medical care shall include preventative and prophylactic care as well as laboratory tests, but shall not include surgery or general anesthesia, for which a separate consent is required under the law.

Authorization for Treatment and Payment:

I consent to the use and/or disclosure of my health information (including the diagnosis or treatment of mental illness, or drug or alcohol abuse, and/or confidential HIV-related information) to any person or organization for the purpose of treatment, including coordination or continuing care and as otherwise authorized by law, conducting certain healthcare operations. This authorization includes the release of all medical information to health care providers who are on staff at Middlesex Health or are integrated within the network and who are directly involved in my care, including the doctors of Middlesex Health Urology. I also understand that my medical information will be maintained in an electronic health information exchange network released to and accessible to the providers listed above. I further consent to the use or disclosure of my health information (including mental illness, drug or alcohol abuse and/or confidential HIV-related information) to any third parties responsible for payment of services furnished to me by or in Middlesex Urology. This may include reviewing or photocopying and/or electronic release of pertinent information for the purpose of obtaining payment. *In the event that any of the information to be released to diagnosis or treatment of mental illness, drug and-or alcohol abuse, and/or confidential HIV-related information. I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by the state and federal law.* This authorization shall expire two years from the date signed below, and is subject to revocation at any time.

Financial Agreement:

I understand that I am obligated to pay Middlesex Health Urology in accordance with the regular rates and terms of the practice, to include a "No Show" fee of $50, where no cancellation or reschedule was received. I agree to pay Middlesex Health Urology for any and all charges not actually paid by insurance benefits, including those charges not covered by my insurance policy and those charges that my insurance company deems to be experimental or medically unnecessary. If my account is not paid, I will pay all court costs, attorney's fees and other costs incurred by Middlesex Health Urology to collect the balance owed. I also authorize payment directly to Middlesex Health Urology.

Consent for Photo Identification:

I hereby consent Middlesex Health Urology to obtain and scan my photo identification card. I agree the staff may use this copy for purposes of patient identification. The copy will remain in my electronic medical chart. The copy will not be used for the purposes other than those stated above, unless additional authorization is obtained.

Acknowledgment:

The undersigned hereby acknowledges that I have read and received a copy of the Middlesex Health Urology HIPAA Privacy Authorization Form.

/ / X

Date **Signature of Patient or Person Granting Authorization on Behalf of Patient**

May release information to: _____

Please list name and relationship to you

MEN ONLY
AUA BPH Symptom Score Questionnaire
Could your male urinary symptoms be caused by BPH?

Patient Name: _____ **Date completed** _____

	Not at All	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished?	0	1	2	3	4	5
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. Intermittency Over the past month, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. Nocturia Over the past 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?	None	1 time	2 times	3 times	4 times	5 or more
	0	1	2	3	4	5+
Total Symptom Score						

Score: 1-7: *Mild* 8-19: *Moderate* 20-35: *Severe*

The possible total runs from 0 to 35 points with higher scores indicating more severe symptoms.
Scores less than seven are considered mild and generally do not warrant treatment.

Disclaimer: This material is provided for information purposes only and is not a substitute for a consultation. You should consult with a urologist regarding your specific symptoms or medical condition.