Patient Registration Form

Name: _____
Last First Middle Initial

Address: _____
Street City State/Zip Code

Date of Birth: _____ Sex: M / F Home Phone: _____

Cell Phone:_____ Work Phone: _____

☐ YES, you have my consent to leave a detailed message on my phone. _____ (initial)

GBU offers a patient portal. The service is free. For access, you will need to set up an account. A password is used so that all your information is private and secure. Please provide your email. A temporary password will be sent to you after your first appointment.

Email: _____

EMERGENCY CONTACT: _____
Last Name First Relationship Phone Number

NEXT OF KIN: _____
Last Name First Relationship Phone Number

Primary Care Physician: _____
Last First Phone Number

_____
Street City State/Zip Code

Cardiologist: _____
Last First Phone Number

_____
Street City State/Zip Code

I hereby authorize Greater Boston Urology to disclose my personal, medical and/or information to the following individuals. This includes:

_____ _____
Name Relationship Name Relationship

☐ None

_____ _____
PATIENT SIGNATURE ***DATE***

Patient Authorization and Acknowledgements

I hereby give my consent to be treated by my Urologist here at Greater Boston Urology.

I authorize the release of any medical reports, findings, and treatment plans to my Physician. Greater Boston Urology will send a written report of our finding and treatment plan to that physician or other healthcare provider as well as periodic updates and other information necessary to process my insurance claims.

I hereby authorize the release of medical information to my insurance company for the purpose of determining benefit eligibility. If there is coverage for my services, I authorize payment directly to the undersigned physician of the surgical and/or medical benefits. I authorize Greater Boston Urology to release all information necessary for the processing of insurance claims to HCFA, its agents, or any other insurance company to determine the benefits payable for related services.

Please sign below to authorize your treatment and the release of this information.

_____ _____

PATIENT SIGNATURE ***DATE***

I acknowledge that I have been provided a copy Greater Boston Urology, Notice of Privacy and Practices that explains my rights as well as documents Greater Boston Urology policies and procedures that will safeguard my private health information.

_____ _____

PATIENT SIGNATURE ***DATE***

I acknowledge the following office policies with my initials:

Referral Policy

For HMO patients or any manage care plan, insurance referrals are due at the time of your visit. This is part of your individual insurance contact. As a courtesy, Greater Boston Urology will make several attempts to make you and your primary care physician aware if you are schedule for an appointment without a referral. Please be advised that the responsibility is ultimately the patients. _____ (initial and date)

Cancellation/ No Show Policy

Greater Boston Urology is committed to helping you manage and maintain your urological healthcare needs. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary, however we ask you to show consideration by calling our office 24 hours in advance. Providing our office with adequate notice will allow us to offer that appointment to another patient in need.
The following fees will be assessed for "NO SHOW "or failing to give 24-hour notice of the need to cancel or reschedule. These charges care not billable to your insurance company and is the sole responsibility of the patient. Subsequent and chronic "no shows" will result in the dismissal from the practice.

$50 charge will be assessed for follow up appointments.
$150 charge will be assessed for all scheduled medical procedures _____ (initial and date)

Laboratory Disclaimer

Please be aware our office utilizes the following laboratories for blood work, specimen and pathology. Please confirm with your insurance company may utilize your individual plan as some insurance companies do manage this: **Greater Boston Urology, CBL Pathology, Metrowest Medical Center, Litholink, Quest.** _____ (initial and date)

PATIENT HISTORY

GREATER BOSTON UROLOGY

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.

Name:_____ Date of Birth _____

Pharmacy Name & Address

_____

PLEASE FILL OUT BOTH SIDES OF THIS FORM COMPLETELY

Chief Complaint – What is the main reason for your visit:

_____

_____

_____

Do you have:

- ❑ Erectile Dysfunction (ED)
- ❑ Sexual Difficulty
- ❑ Leakage
- ❑ Low Testosterone

Allergies to Medications?

____ No Known Drug Allergies

If Yes (Please list)

_____

_____

_____

Medications (Include vitamins & Herbal Supplements)

___No Medications ___ Medication List Attached

Medications:

_____

_____

_____

Surgical History

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Medical History

List any personal illnesses/conditions

_____

_____

_____

_____

Family History

List any immediate family with any major illnesses (Ex: Prostate, Bladder, or Kidney Cancer, Diabetes, Heart Disease, etc.)

_____

_____

_____

Race:

- ☐ Caucasian
- ☐ African American
- ☐ Hispanic
- ☐ American Indian
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Declined to Specify

Language:

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Portuguese
- ☐ German
- ☐ Russian
- ☐ Chinese

Social History:

Marital status: ❑Married ❑Divorced ❑Single ❑Widowed Occupation: _____

Smoke: ❑Current – Everyday
❑Current – Some days
❑Former
❑Never

Alcohol: ❑ Current – Social, Light, Moderate, Excessive
❑Former
❑ Never

Height: _____ Weight: _____

Daily cups of Caffeine: ❑0 ❑1 ❑2 ❑3 ❑ 4+

Colonoscopy: ❑ I have had a colonoscopy. Year: _____
❑ I have NOT had a colonoscopy.

Pneumococcal Vaccine (Pneumonia Vaccine) ❑ I have had a pneumonia vaccine.
❑I have NOT had a pneumonia vaccine.

REVIEW OF SYSTEMS

Please *Circle* if you **currently** have any of the following:

Constitutional	Fever	Chills	Headache	Weight Loss	
Eyes	Blurred Vision	Double Vision	Cataracts		
Allergic/Immunologic	Hay Fever	Drug Allergies	Wheezing	Shortness of Breath	
Neurological	Tremors	Dizzy Spells	Numbness/Tingling		
Endocrine	Excessive Thirst	Too Hot/Cold Intolerance	Tired/Sluggish		
Gastrointestinal	Abdominal Pain	Nausea/Vomiting	Indigestion/Heartburn	Change in Bowels	
Cardiovascular	Chest Pain	Varicose Veins	High Blood Pressure	Irregular Heartbeat	
Integumentary	Skin Rash	Boils	Persistent Itch	Skin Cancer History	
Musculoskeletal	Joint Pain	Neck Pain	Back Pain	Swollen Ankles	Sore Muscles
Ear/Nose/Throat/Mouth	Ear Infection	Sore Throat	Sinus Problems/Nasal Stuffiness	Hearing Loss	Chronic Cough
Genitourinary	Urine Retention	Painful Urination	Urinary Frequency	Incontinence	Blood in Urine
Respiratory	Wheezing	Frequent Cough	Shortness of Breath		
Hematologic/Lymphatic	Swollen Glands	Blood Clotting Problem	Abdominal Bleeding	Transfusion History	