

# Alaskan Interior Urology

Medical Dental Arts Bldg.  
1919 Lathrop St, Suite 207  
Fairbanks, AK 99701

## ADULT REGISTRATION FORM

Do you wish your family financial record to be listed in the patient or spouse name? Please check one:  Patient  Spouse  
Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Spoken Language: \_\_\_\_\_

PLEASE PRINT

### PATIENT INFORMATION

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Social Security No. \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer (If self, name of business) \_\_\_\_\_ Dept./Position Held \_\_\_\_\_ Union/Local No. \_\_\_\_\_ Work Phone/Ext \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_ Address \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### SPOUSE INFORMATION

Spouse Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Social Security No. \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer (If self, name of business) \_\_\_\_\_ Dept./Position Held \_\_\_\_\_ Union/Local No. \_\_\_\_\_ Work Phone/Ext. \_\_\_\_\_

COMPLETE FOR EACH COMPANY (please bring your insurance card to the appointment)

Insurance Company	Primary Insurance	Secondary Insurance	Tertiary Insurance	Other Insurance
Insurance Address				
Identification No.				
Policy or Group No.				
Family Members Covered				
Policy Holder's Name				
Policy Holder's SSN And Date of Birth				
Relationship to Patient				

AUTHORIZATION: I understand full payment received is my responsibility regardless of my insurance coverage. I hereby authorize the Clinic to release my insurance information acquired in the course of examination or treatment. I further authorize my insurance company to pay directly to the Clinic any medical/surgical benefits due to me that have not been paid in full. This authorization shall expire upon written notice or one year from this date.

**SIGNATURE**

**Date**

**We ask that all patients arrive at their "Check In" time, there is a 15 minute "Grace Period" after that time has expired you will be considered a "No Show" and will be susceptible to the "No Show Fee" of \$30. If you are running late please call at let us know so we may adjust accordingly**

## HPAA CONSENT FORM

I give Alaskan Interior Urology, LLC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Alaskan Interior Urology, LLC's Notice Of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Alaskan Interior Urology, LLC is not required to agree to the request. If Alaskan Interior Urology, LLC agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

May we leave a detailed message at the phone numbers you have listed? Yes  No

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient, parent or guardian

Please list any family member(s) that you would like to allow us to discuss your medical treatment and care with:

\_\_\_\_\_

If signed by patient representative, state relationship to patient: \_\_\_\_\_

ALASKAN INTERIOR UROLOGY  
1919 Lathrop St, Suite 207  
FAIRBANKS, AK 99701  
907-458-0700

A clear understanding of your financial responsibility for care is essential in assuring a professional relationship with our staff. Please read this form carefully and have your questions answered before signing.

**Payment:** We accept cash, checks or visa and master card.

**Insurance:** Remember-You are ultimately responsible for your bill. If you have private insurance, as a courtesy, we will bill your Insurance for our services once per visit or procedure. All patients are asked to pay the full amount for services at the beginning of each year until deductible is met. You will then be expected to pay your "co-pay" at each following visit. Any overpayments will be refunded to the appropriate party. If there is a balance left after your insurance has paid, you will be billed; that amount is due upon receipt of your first statement from our office. If your Insurance has not paid for any reason, you will be billed and are responsible for the charges on receipt of your first statement from our office. Please remember that insurance is a contract between you and your insurer. We will be happy to help if we can but will not become involved in disputes concerning deductible, co-payments, secondary insurance or so-called "usual and customary" reductions by your insurer.

**Medicare Patients:** Please remember that you have a yearly deductible and co-pay for each visit. **Medicaid Patients:** Please be prepared to pay your \$3.00 co-pay at time of service.

**Veteran's Administration Patients:** You are required to get **PRE-AUTHORIZATION** before each visit if you want VA to pay. A 5 day notice is now required by VA; it is your responsibility to see this is done. VA authorization must be received in our office before each visit. If no authorization is received, you will be expected to pay in full at the time of your visit.

**Chief Andrew Isaac Health Center Patients:** You must bring a purchase order from Contract Health for each and every visit. This is their requirement for us to be paid. If no purchase order is provided, you will be expected to pay at the time of service unless you have Medicaid coupons.

**Workers Compensation:** No retroactive filing will be done by our office. If it is work-related, you must state that at the time of service and be prepared with all necessary information.

If you fail to cancel and do not show for any appointment, you will be charged a \$30 fee. This fee will be billed directly to you and not your insurance. After 3 no shows, no further appointments will be made for you. **Mail Returns (no forwarding address):** Upon return to our office, these accounts will be sent immediately to our Collection Agency.

**Delinquent Accounts:** Past due accounts may be referred to our Collection Agency for collections. You will be responsible for all collection fees incurred in addition to the past due balance. There will be a 50% handling fee added if your account is sent to collections. Once an account has been placed with the Collection Agency, all questions must be directed to their office. Additionally we will not be liable for any consequences which may result from a collection agency's effort to obtain payment.

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Printed Name

Signature

Date

**ALASKAN INTERIOR  
UROLOGY ASSIGNMENT  
OF BENEFITS**

I authorize and request that payment be made to Alaskan Interior Urology for services rendered. I agree that this authorization will cover *all* medical services rendered until such authorization is revoked by me. A copy of this form may be used in lieu of original document.

Your insurance company may request chart notes in order to process your claim. By signing below, you are authorizing us to release pertinent clinical information to your insurance company.

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Patient Signature

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Parent Signature (if patient is minor child)

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Date

# UROLOGY - Patient information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

How long have you had this problem/pain? \_\_\_\_\_

What improves/worsens the problem/pain? \_\_\_\_\_

Are there any symptoms that go along with the problem/pain? \_\_\_\_\_

Is the problem/pain continuous, or does it come and go? \_\_\_\_\_

What is the nature of the pain? (sharp, dull, etc.) \_\_\_\_\_

Have you tried any medicine/treatment or seen a doctor for this problem before this visit? \_

## Review of Genitourinary Systems

Please mark with an 'x' if you **have or have ever had** any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Back Pain                    | <input type="checkbox"/> Prostatitis               | <input type="checkbox"/> Urine Retention            |
| <input type="checkbox"/> Bedwetting                   | <input type="checkbox"/> Prostate cancer           | <input type="checkbox"/> Urologic Cancer            |
| <input type="checkbox"/> Blood In Urine               | <input type="checkbox"/> Sensation of not emptying | <input type="checkbox"/> Urologic Surgery           |
| <input type="checkbox"/> Dribbling                    | <input type="checkbox"/> Bladder Pain              | <input type="checkbox"/> Vaginal Bleeding           |
| <input type="checkbox"/> Burning on urination         | <input type="checkbox"/> Testes/Scrotal Swelling   | <input type="checkbox"/> Vaginal Discharge/Problems |
| <input type="checkbox"/> Erection/Ejaculation problem | <input type="checkbox"/> Urgency                   | <input type="checkbox"/> Weak stream                |
| <input type="checkbox"/> Flank pain                   | <input type="checkbox"/> Urinary Frequency         | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Kidney disease               | <input type="checkbox"/> Urinary Hesitancy         | _____   |
| <input type="checkbox"/> Kidney failure               | <input type="checkbox"/> Urinary Incontinence      | _____   |
| <input type="checkbox"/> Kidney infections            | <input type="checkbox"/> Urinary Tract Infection   | _____   |
| <input type="checkbox"/> Kidney or bladder stones     |  |   |
| <input type="checkbox"/> Up at night to urinate       |  |   |

# Review of Systems

Please mark with a 'x' if you **currently have** any of the following conditions:

## **Constitutional**

- Appetite Change
- Chills
- Fever
- Fatigue
- Night Sweats
- Weight Loss
- Other \_\_\_\_\_

## **Eyes**

- Blindness
- Blurred vision
- Glaucoma
- Other \_\_\_\_\_

## **Neurological**

- Dizzy spells
- Headache
- Leg or arm weakness
- Memory loss
- Numbness/tingling
- Stroke
- Other \_\_\_\_\_

## **Endocrine**

- Diabetes
- Pituitary disease
- Thyroid disease
- Other \_\_\_\_\_

## **Gastrointestinal**

- Abdominal pain
- Acid reflux
- Bloody stools
- Constipation
- Diarrhea
- Hemorrhoids
- Indigestion/heartburn
- Nausea/vomiting
- Rectal bleeding
- Tarry Stool
- Other \_\_\_\_\_

## **Cardiovascular**

- Chest pain/angina
- Heart attack

- Heart failure
- Heart murmur
- High blood pressure
- Irregular heartbeat
- Palpitation
- Other \_\_\_\_\_

## **Skin**

- Skin rash
- Other \_\_\_\_\_

## **Musculoskeletal**

- Arthritis
- Back pain
- Joint pain
- Muscle cramps
- Other \_\_\_\_\_

## **Ears/Nose/Throat**

- Ear infection
- Sinus Problems
- Other \_\_\_\_\_

## **Respiratory**

- Asthma
- Emphysema-Bronchitis
- Frequent cough
- Shortness of breath
- Other \_\_\_\_\_

## **Hematologic/Lymphatic**

- Bleeding problems
- Blood dotting problem
- Hepatitis
- HIV (AIDS)
- Sickle Cell
- Swollen glands
- Other \_\_\_\_\_

## **Psychological**

- Anxious
- Depressed
- Generally satisfied with life
- Other \_\_\_\_\_

For each of the eight questions below, please check the one box that best describes your symptoms.

The International &foible Committee (SCI), under the patronage of the World Health Organization (WHO) and the International Union Avenel Cancer (UICC), has weed to use the symptom index for BPH. which has been developed by the American Urological Association (ALLA) Measurement Committee. Worldwide symptoms assessment tool for patients suffering from prostatism.	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
<b>Incomplete emptying</b> Over the past month, how often have you had a sensation of not emptying your bladder after you finished urinating?	0	1	2	3	4	5
<b>Frequency</b> 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
<b>Intermittency</b> Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
<b>Urgency</b> Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
<b>Weak Stream</b> Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
<b>Straining</b> Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
<b>Nocturia</b> Over the past month, how many times did you get up to urinate from the time you went to bed until the time you got up?	0	1	2	3	4	5
<b>Quality of Life Due to Urinary Symptoms</b>	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly dissatisfied	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5

**Past Medical History** Please mark with an 'x' if you **have a history** of any of the following conditions:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcoholism               | <input type="checkbox"/> Diabetes mellitus       | <input type="checkbox"/> Kidney infection       |
| <input type="checkbox"/> Alzheimers Disease       | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Migraine               |
| <input type="checkbox"/> Anemia (type) _____      | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Mitral Stenosis        |
| <input type="checkbox"/> Angina                   | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Mitral insufficiency   |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> GERD                    | <input type="checkbox"/> Mitral valve prolapsed |
| <input type="checkbox"/> Arrhythmia               | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Aortic aneurysm          | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Peptic ulcer           |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Phlebitis              |
| <input type="checkbox"/> Atrial fibrillation      | <input type="checkbox"/> Heart Disease _____     | <input type="checkbox"/> Prostatitis            |
| <input type="checkbox"/> Bleeding disorder        | <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Prostate Cancer        |
| <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> Rheumatic fever        |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Colitis                  | <input type="checkbox"/> Herniated disc          | <input type="checkbox"/> Transplant Recipient   |
| <input type="checkbox"/> Constipation             | <input type="checkbox"/> Hiatal hernia           | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Crohn' s disease         | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Cancer type _____      |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritable bowel disease | <input type="checkbox"/> Other _____            |
|   | <input type="checkbox"/> Kidney disease          | _____   |

## Surgical History

Please list all surgeries you have had and note the date:

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## Family History

Please indicate which family member has / had any of the following:

- Bedwetting \_\_\_\_\_  Bladder cancer \_\_\_\_\_  Breast cancer \_\_\_\_\_  
 Cervical cancer \_\_\_\_\_  Colon cancer \_\_\_\_\_  Diabetes mellitus \_\_\_\_\_  
 Kidney Cancer \_\_\_\_\_  Kidney Stones \_\_\_\_\_  Prostate Cancer \_\_\_\_\_

## Social History

### Marital Status

- Single  Married/#years \_\_\_\_\_  Separated  Divorced  Widowed  Life Partner

### Dependents:

Please indicate # of children you have.

\_\_\_\_ Sons \_\_\_\_ Daughters \_\_\_\_ Stepchildren Other: \_\_\_\_\_

### Occupation:

Please circle one that applies: None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired Description: \_\_\_\_\_

**Alcohol Consumption:** \_\_\_\_ None \_\_\_\_ Yes \_\_\_\_ Occasional/social \_\_\_\_ # of drinks per day

**Tobacco per day:** \_\_\_\_ None \_\_\_\_ Yes \_\_\_\_ Cigarettes \_\_\_\_ Pipe \_\_\_\_ Smokeless Tobacco

If yes: \_\_\_\_ #packs/day \_\_\_\_ #cigarettes/day \_\_\_\_ #yrs/smoked

If you previously stopped, when? \_\_\_\_\_ How long? How much? \_\_\_\_\_

**Recreational drugs:** \_\_\_\_ None If yes, please list: \_\_\_\_\_

**Caffeinated beverages:** \_\_\_\_ None \_\_\_\_ Low \_\_\_\_ Moderate \_\_\_\_ High/Excessive

\_\_\_\_ Coffee \_\_\_\_ #cups/day \_\_\_\_ Soda \_\_\_\_ #cups/day

### Recent Foreign Travel (please circle all that apply)

None

Americas: Canada, Mexico, Latin America, South America, Other \_\_\_\_\_

World Wide: Europe, Africa, Middle East, Asia, Australia, Other \_\_\_\_\_

### Current Medications

Please list ALL medications you are currently taking. Include any over-the-counter drug (s).

Drug Name Strength Directions/How you take it

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**Pharmacy Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

### Allergies:

Please list ALL types (drug, seasonal, pets, animals, environmental, foods)

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