ASSOCIATED UROLOGISTS
OF NASHVILLE, LLP
Adult Urology

Medical Information Release Form (HIPAA Release Form)

Name: ___________________________________ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____

[ ] Child(ren)______________________________________

[ ] Other____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________ If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____

Please email:_______________________________________ Regarding my:

[ ] Lab Results

[ ] Upcoming appointments

[ ] ____

The best time to reach me is (day)___________________ between (time)_________

Signed: ______________________________________ Date: ____/____/_____

Witness:______________________________________ Date: ___/____/______

International Prostate Symptom Score (IPSS)

ASSOCIATED UROLOGISTS OF NASHVILLE, LLP
Adult Urology

Patient Name: ______________________ Today's Date: ______________________

BPH (Benign Prostatic Hyperplasia) is a non-cancerous enlargement of the prostate that occurs in many men over the age of 40.

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – 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 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = ________

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	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	6

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)

1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

What is your level of frustration with your medications? (circle)

1	2	3	4	5	6	7	8	9	10

Not Frustrated *Very Frustrated*

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No

©2017 NeoTract Inc. All rights reserved. MA00075-09 Rev A

PATIENT REGISTRATION FORM

Please answer all questions to the best of your ability

PATIENT INFORMATION

Patient Name:_________________________ Date of Birth: ________________ Social Sec. #:__________________ Sex: M F

Spouse Name:_________________________ Date of Birth:________________ Social Sec. #___________________ Sex: M F

Current Address: ____

Street City State Zip

Cell Phone: (___)________________ Home Phone: (___)________________

Email:____

Is Patient Currently in a Skilled Nursing Facility or Hospice Care? Y N Name:____________________ Phone:________________

ADDITIONAL INFORMATION

Referring M.D.____________________ Phone:____________ Family M.D._____________ Phone:____________

Patients Employer:____________________________________ Occupation:_____________ Phone:___________

Next of Kin: (Someone who does not live with you, in case of emergencies)

Name:____________________________ Relationship:_______________________

Address:____ Phone:_______________________

Do you have a living Will? ☐ Yes ☐No

Do we have permission to leave messages concerning your appointments and care on your answering machine? ☐Yes ☐No

Do you Authorize Associated Urologists of Nashville, LLP to electronically submit all of your prescriptions and refills? ☐Yes ☐No

Do you Authorize Associated Urologists of Nashville, LLP to mail your test results to the above listed address? ☐Yes ☐No

Do you authorize Associated Urologists of Nashville, LLP to download your medications from a prescription hub? ☐Yes ☐No

HIPAA

Per HIPAA regulations, I hereby authorize Associated Urologists of Nashville, LLP and its employees to discuss my health, financial and/or insurance information with myself and with:

Name:____ Relationship:___________________________________

INSURANCE INFORMATION

1. We Need to make a copy of your insurance card(s).
2. Does your insurance require: ☐ Referral Number ☐Precertification ☐Second Opinion
3. Do you have Medicare HMO? ☐Yes ☐No

PRIMARY COVERAGE
(Usually the Patients Insurance)

Name of Insurance Company:________________________

Policy Holder Name: ______________________________

Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other_________________________________

Member ID # ____________________________________

SECONDARY COVERAGE
(The spouses insurance is secondary if patient has insurance coverage)

Name of Insurance Company:________________________

Policy Holder Name: ______________________________

Patient Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other_________________________________

Member ID # ____________________________________

INSURANCE RELEASE/PATIENT RESPONSIBILITY

1. I request that payment of authorized insurance benefits be made on my behalf to the physicians of Associated Urologists of Nashville, LLP for any services they provide to me. I authorize any holder of medical information about me, to release, to the insurance company any information needed to determine these benefits or the benefits payable for related services. ________
   Initial
2. I hereby authorize this office to release any information acquired to establish a health insurance claim. I authorize this office to obtain previous medical records from other physicians and/or medical facilities, including but not limited to information regarding treatment of drug or alcohol abuse, psychological conditions, HIV testing or an AIDS related condition. ________
   Initial
3. I understand that I am personally responsible for all Charges including deductibles, co-pays, non covered services and any amount not covered by my insurance (except in cases of a contractual agreement between my insurance carrier and my physician). I understand the charges I am responsible for are to be paid at the time of service. Should collection proceedings become necessary, I understand that I will be responsible for a reasonable attorney fees, court cost and all collection cost. _______
   Initial
   - Associated Urologists of Nashville, LLP charges $35.00 for a returned check and future services must be paid for with cash, money order or cashier's check. _________
     Initial
   - Associated Urologists of Nashville, LLP requires a 24 hour cancellation notice to avoid any charges. We reserve the right to charge $35.00 for no-show appointments without a 24 hour cancellation notice. ________
     Initial
   - Associated Urologists of Nashville, LLP charges $30.00 for completion of FMLA, disability and life insurance application forms. ________
     Initial
   - Associated Urologists of Nashville, LLP charges $25.00 for doing prior authorizations for medications if required by your insurance company. _______
     Initial
4. I authorize my health care provider to use an automated telephone system and/or email to use my name, address, and phone number; the name of my scheduled treating physician, and the time and place of my scheduled appointment or other health care related communication. I also authorize my health care provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments and to leave a reminder message on my voice mail system or answering machine. _____
   Initial
5. I understand that a copy of Associated Urologists of Nashville, LLP privacy practices is available upon request. _______
   Initial
6. I consent to treatment by the Physicians of Associated Urologists of Nashville, LLP/ These Policies supersede and replace any prior policies, verbal or published. _______
   Initial

____   ____________________________________

Patient Name   Patient Date of Birth

____   ____________________________________

Patient Signature   Date

Patient

Intake Form

ASSOCIATED UROLOGISTS OF NASHVILLE, LLP

Adult Urology

Please Circle Race:
African American   Asian
American Indian   Black
Alaskan Native   Hispanic
Native Hawaiian
Caucasian
Other Pacific Islander
Unknown
Other:________

Please circle Ethnicity:
Hispanic   Non Hispanic
Latino   Unknown

Name:______________________________ Date of Birth: ____/_____/____

Age:_________ Weight:_________ Height:_______ Gender:____________

Primary Dr.:_____________________Referring Dr.:___________________

What is the main reason for your visit?______________________________

Preferred Language:_______________ Occupation:___________________

MEDICATION & ALLERGY LIST				
ALLERGIES: None Codeine IVP dye Latex Mycins Penicillin Sulfa Drugs OTHER ALLERGIES: ______________________ ______________________ PHARMACY NAME & ADDRESS: ______________________ ______________________ PHARMACY PHONE & FAX NUMBERS:______________________				
DATE	PLEASE LIST CURRENT MEDICATIONS	DOSAGE	FREQUENCY	NOTES
	(Include over-the-counter drugs, vitamins, herbals)			

Check any past medical problems:

- ☐ Acid reflux
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer; Type______
- ☐ Chronic UTIs
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: # of years:____
- ☐ Diverticulitis
- ☐ Enlarged Prostate
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Neurologic Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinsons
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Valvular Heart Disease

Other: ____

____

Check any past surgical History :

	Date:
☐ Appendectomy	______
☐ Back Surgery	______
☐ Heart Bypass	______
☐ Colon Surgery	______
☐ Heart Stent	______
☐ Cystoscopy	______
☐ Gallbladder Removal	______
☐ Gastric Bypass	______
☐ Hernia Repair	______
☐ Hip Replacement R / L	______
☐ Kidney Removal R / L	______
☐ Kidney Stone Removal	______
☐ Knee Replacement R / L	______
☐ Laparoscopy	______
☐ Pacemaker	______
☐ Tonsillectomy	______

Gender Specific: Female	Date:
☐ Bladder Suspension	______
☐ Breast Biopsy	______
☐ Cesarean Section #___	______
☐ Hysterectomy	______
☐ Mastectomy R / L	______
☐ Pubovaginal Sling	______
☐ Tubal Ligation	______
☐ Vaginal Delivery # ___	______
☐ Total Pregnancies #___	______
☐ Menopause	______
☐ Hormone Replacement Therapy	______
☐ Other:	

____

____

____

Gender Specific: Male	Date:
☐ Prostate Surgery	______
☐ Penile Prosthesis	______
☐ Prostate Biopsy	______
☐ Scrotal Area Surgery	______
☐ Testicle Removal	______
☐ Varicocele Surgery	______
☐ Vasectomy	______
☐ Other:	

____

____

____

____

____

____

____

____

Check any family history of Illness

Adopted? N Y	Father	Mother	Brother	Sister	Grandparent	Son	Daughter	Runs in Family
☐ Diabetes								
☐ Enlarged Prostate								
☐ High Blood Pressure								
☐ Kidney Stones								
☐ Kidney Failure								
☐ Prostate Cancer								
☐ Kidney Cancer								
☐ Bladder Cancer								
☐ Stroke								
☐ Urinary Tract Infections								
☐ Cancer, Other								

Social History

MARITAL STATUS: S M D W Children? N Y # of Sons______ # of Daughters__________

TOBACCO USE: ☐ Current ☐ Former ☐ Never ☐ Unknown Type:____________ Units per day_____ Years Used ____

DRUG USE: ☐ Current ☐ Former ☐ Never ☐ Unknown Type:___________ Years Used_____

Have you tried to quit? N Y Year quit:______ Passive Smoke Exposure? N Y

Smoker Status: ☐ Current, Every Day ☐ Current status unknown ☐ Former Smoker ☐ Current, Some day smoker
☐ Never Smoker ☐ Unknown if ever smoked

CAFFEINE: N Y Type: _________________________________ Amount of caffeine per day_______________

ALCOHOL: Drinks alcohol: N Y Formerly Type: ___________ Frequency:_____ Amount:_____ Last Drink:_________

IMMUNIZATIONS: Tetanus Y N _______ Influenza Y N _______ Pneumonia Y N _______
Date: Date: Date:

Review of Systems: Check if you are currently experiencing any of the following symptoms. Please mark Yes or No for each selection. Additional information may be added in the notes section at the bottom of the page.

Constitutional:
No Yes
☐ ☐ Chills
☐ ☐ Fever
☐ ☐ Weight Loss
Other:

Gastrointestinal:
No Yes
☐ ☐ Blood in stool
☐ ☐ Abdominal Pain
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Increased abdominal girth
☐ ☐ Heartburn
☐ ☐ Nausea/Vomiting
Other:

Reproductive-Female:
No Yes
☐ ☐ Breast Lumps
☐ ☐ Breast pain
☐ ☐ Vaginal Discharge
Other:

Skin:
No Yes
☐ ☐ Hives
☐ ☐ Itching skin
☐ ☐ Rash
☐ ☐ Skin Lesion
Other:

Eyes/Ears/Nose/Throat:
No Yes
☐ ☐ Blurred/Double Vision
☐ ☐ Hearing Loss
☐ ☐ Headache
☐ ☐ Sinus infection
☐ ☐ Sore Throat
☐ ☐ Cataracts
Other:

Genitourinary:
No Yes
☐ ☐ Burning with urination
☐ ☐ Blood in Urine
☐ ☐ Urinary Frequency
☐ ☐ Urinary Incontinence
☐ ☐ Inability to urinate
Other:

Metabolic/Endocrine:
No Yes
☐ ☐ Fatigue
☐ ☐ Male Breast enlargement
☐ ☐ Hot flashes
☐ ☐ Thyroid Disorder
Other:

Musculoskeletal:
No Yes
☐ ☐ Back Pain
☐ ☐ Joint Pain
☐ ☐ Neck Pain
☐ ☐ Muscle Pain
Other :

Respiratory :
No Yes
☐ ☐ Chronic Cough
☐ ☐ Shortness of Breath
☐ ☐ Wheezing
☐ ☐ Known TB exposure
Other:

Reproductive- Male:
No Yes
☐ ☐ Penile Discharge
☐ ☐ Erectile dysfunction
Other :

Neurological:
No Yes
☐ ☐ Headache
☐ ☐ Memory Loss
☐ ☐ Seizures
☐ ☐ Stroke
☐ ☐ Tremors
Other:

Hematologic/Lymphatic:
No Yes
☐ ☐ Easy Bleeding
☐ ☐ Swollen Glands
☐ ☐ Sickle Cell
Other:

Cardiovascular :
No Yes
☐ ☐ Chest pain at rest
☐ ☐ Chest pain at exertion
☐ ☐ Heart Murmur
☐ ☐ Leg Cramps with exercise
☐ ☐ Palpitations
☐ ☐ Arrhythmia
☐ ☐ Sleep apnea
Other:

Psychiatric:
No Yes
☐ ☐ Anxiety
☐ ☐ Depression
☐ ☐ Bipolar
☐ ☐ Schizophrenia
Other:

Allergy:
No Yes
☐ ☐ Diabetes
☐ ☐ Immune Deficiency
☐ ☐ HIV/AIDS
☐ ☐ Hepatitis C
Other:

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: ________________________________ **TODAY'S DATE:** ____________

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		VERY LOW	LOW	MODERATE	HIGH	VERY HIGH
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	NO SEXUAL ACTIVITY	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	DID NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	DID NOT ATTEMPT INTERCOURSE	EXTREMELY DIFFICULT	VERY DIFFICULT	DIFFICULT	SLIGHTLY DIFFICULT	NOT DIFFICULT
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	DID NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. **TOTAL:** ___________

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED **8-11 Moderate ED** **12-16 Mild to Moderate ED** **17-21 Mild ED**