NORTHWEST ARKANSAS UROLOGY ASSOCIATES
NEW PATIENT HISTORY FORM

Name: _____ **Today's Date:** _____

Date of Birth: _____ **SSN:** _____

Referring Doctor: _____ **Family Doctor:** _____

Why are you seeing the doctor today? _____

_____

How long have you had this problem? _____

What improves or worsens the problem? _____

Please describe your symptoms and pain related to this problem: _____

_____

Have you tried any medicine/treatment for this problem/pain? _____

CURRENT MEDICATIONS - **Please list ALL medications you are currently taking including over the counter meds and supplements/herbs OR note if you are not taking any medications**

Drug Name:	Strength:	Directions/How you take it:

Attach list if necessary

Pharmacy Name/Location: _____ **Phone #:** _____

ALLERGIES - **Please list ALL types and REACTION (Drug, seasonal, pets, environmental, foods)**

_____

_____

Any recent imaging (cat scan, ultrasound, xray, MRI, etc.) If so, where: _____

_____

NORTHWEST ARKANSAS UROLOGY ASSOCIATES
NEW PATIENT HISTORY FORM

Name: _____

REVIEW OF SYSTEMS: (Please circle if you have or currently experience)

Constitutional
Chills
Fever
Fatigue
Generalized Weakness
Weight Gain
Weight Loss
_____

Eyes
Blindness
Blurred Vision
Double Vision
Pain
_____

Ear/Nose/Throat
Ear infection
Sinus infection
Sore Throat
_____

Respiratory
Cough
Shortness of breath
Wheezing
_____

Cardiovascular
Palpitation (racing heart)
Swelling of legs
Difficulty laying flat
_____

Gastrointestinal
Abdominal Pain
Bloody Stools
Constipation
Diarrhea
Hemorrhoids
Heartburn
_____

Musculoskeletal
Back Pain
Joint Pain
_____

Skin
Changing Moles
Skin rash

Neurological
Disoriented
Dizzy Spells
Headache
Memory Loss
Numbness
Speech Disorder
Tremors
Tingling
_____

Genitourinary
Bedwetting
Blood in Urine
Burning on Urination
Erection Problems
Incomplete Emptying
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Penile/Vaginal Discharge
Vaginal Bleeding
Weak Stream
_____

Endocrine
Excessive thirst
Too Hot/Cold
_____

Hematological/ Lymphatic
Swollen Glands
Blood clot
_____

Psychological
Anxiety
Depressed
_____

Other: _____

If none of these apply, please initial here so we know this section has been reviewed by you. _____

FAMILY HISTORY

Indicate which family member has/had any of the following and indicate if they are living or deceased:

(Mother, Father, Brother, Sister, Grandmother, Grandfather, Uncle, Aunt)

Bladder Cancer _____
Breast Cancer _____
Colon Cancer _____
Heart Attack _____
Hypertension _____
Kidney Disease _____
Kidney Stones _____
Multiple Sclerosis _____
Prostate Cancer _____
Stroke _____

If none of these apply, please initial here so we know this section has been reviewed by you. _____

NORTHWEST ARKANSAS UROLOGY ASSOCIATES
NEW PATIENT HISTORY FORM

Name: _____

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cancer
Bladder
Brain
Breast
Cervical
Colon
Kidney
Lung
Lymphoma
Melanoma
Ovarian
Pancreatic
Prostate
Rectal
Scarcodosis
Testicular
Ureteral
Uterine

Cardiovascular/Circulatory
Anemia
Aortic Aneurysm
Arrhytmia
Atrial Fibrillation
Cerebrovascular Disease
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Heart Attack
Heart Murmur
Heart Valve Disease
High Blood Pressure
Varicose Veins

GI
Chronic Liver Disease
Crohn's Disease
Gallbladder Disease
GERD
Hemorrhoids
Hepatitis - A, B or C
Hiatal Hernia
Pancreatitis
Ulcerative Colitis

Endocrine/Metabolic
Diabetes
Gout
Hypothyroid
Hyperthyroid
Elevated Cholesterol
Elevated Lipids

HEENT
Blindness
Cataracts
Deafness
Ear Infections
Glaucoma
Mumps
Sinusitis

GU
AIDS/HIV
Bladder Infection
Bladder Prolapse
Blood in urine
Kidney Disease
Impotence
Interstitial Cystitis
Kidney Disease
Kidney Infection
Kidney Stones
Libido Decreased
Neurogenic Bladder
Undescended Testicle
Urinary Tract Infection
Venereal Disease (type: _____)

Musculoskeletal
Arthritis
Carpal Tunnel Syndrome
Fibromyalgia

Neuro/Psych
ADD/ADHD
Alcoholism
Alzheimer's Disease
Bi-polar Disorder
Depression
Epilepsy
Migraine
Multiple Sclerosis
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke

GYN/OB
Abnormal Pap smear
Endometriosis
Menstrual Problems

Respiratory
Asthma
Bronchitis
COPD
Emphysema
Pneumonia
Pulmonary Embolism
Sleep Apnea
Tuberculosis

General
Exposure to Chemicals (Chemical Name: _____)

Other

_____
_____

If none of these apply, please initial here so we know that you have reviewed this section: _____

SOCIAL HISTORY

Please provide the following information:

Do you drink alcohol? Y/N Beer / Wine / Hard Liquor How Often? Socially/Occasionally Light/Heavy

Do you use tobacco? Y/N Cigarettes (Packs per day ____)/ Cigar / Pipe / Chew / Dip

If you previously used tobacco, when did you stop and what kind did you use (cigarette/cigar/pipe/dip)?

_____

NORTHWEST ARKANSAS UROLOGY ASSOCIATES
NEW PATIENT HISTORY FORM

Name: _____

SURGICAL HISTORY

Please CIRCLE if you have had any of the following surgeries and approximate year of surgery:

Cardiovascular
Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery (Stents)
Pacemaker Insertion
_____

GI
Appendix removal
Bariatric Surgery (Weight Loss)
Bowel/Colon Surgery
Gallbladder Surgery
Hemorrhoid Surgery
Liver Surgery
Lysis Adhesions
Nissen Fundoplication (Reflux surgery)
Spleen Surgery
Stomach Surgery
_____

HEENT
Ear Surgery
Eye Surgery
Facial Surgery
Sinus Surgery
Tonsil Removal
Thyroid Surgery
_____

General
Brain Surgery
Lymph Node Surgery
Thyroid Surgery
_____

GU
Bladder Surgery (Sling/Tumor/Removal)
Circumcision
Scrotal/Testicular Surgery (removal/hydrocele)
Hernia Surgery
Interstim (Bladder Pacemaker)
Kidney removed
Kidney Stone (ESWL/ Ureteroscopy)
Penile Implant
Prostate Surgery (prostate biopsy/ removal/ TURP)
Renal Transplant
Vasectomy
_____

Musculoskeletal
Amputation
Back/Disc Surgery
Carpal Tunnel Surgery
Spinal Surgery
Foot Surgery
Hip Surgery
Knee Surgery
Shoulder Surgery
_____

GYN
C-section
Hysterectomy-Partial
Hysterectomy-Total
Lumpectomy
Breast Surgery
Tubal Ligation
_____

Respiratory
Lung Surgery
_____

Skin
Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma
_____

Other: _____

If none of these apply, please initial here so we know that you have reviewed this section: _____

NORTHWEST ARKANSAS UROLOGY ASSOCIATES
PATIENT INFORMATION

Patient's Last Name:_____ First Name:_____ MI:_____

Patient's Social Security #_____ Patient's Date of Birth:_____

Home phone:_____ Cell Phone:_____ Alternate Phone:_____

Mailing Address:_____
STREET CITY STATE ZIP

Physical Address:_____
STREET CITY STATE ZIP

Sex: Male___ Female___ Age:_____ Spouse/Parent Name:_____

Email Address: _____

(CIRCLE ONE): Single / Married / Separated / Divorced / Widowed LANGUAGE (CIRCLE ONE): English, Spanish, Other STUDENT STATUS (CIRCLE ONE): Full-Time / Part-Time / Non-Student	RACE (CIRCLE ONE): African-American Caucasian Hispanic Other: _____ ETHNICITY: Hispanic or Latino YES / NO (CIRCLE ONE)	**I have had an opportunity to read and receive a copy of NWA Urology Associates Notice of Privacy Practices** _____ Signature Date **Patient did not wish to read and/or receive a copy of NWA Urology Associates Notice of Privacy Practices and/or did not wish to sign the written acknowledgment form.** _____ Signature of NWAU Staff Member Date

Guarantor Last Name:_____ First Name:_____ MI:_____

Guarantor Social Security #:_____ Guarantor Date of Birth:_____

Guarantor Address:_____
STREET CITY STATE ZIP

Relationship to Patient:_____

Emergency Contact Name:_____ Phone_____ Relationship to patient:_____

Where did you hear about us?_____

INSURANCE INFORMATION

Insurance:_____ Self-Pay:_____
Please have insurance cards ready for receptionist

Policy Holder Last Name:_____ First Name:_____ MI:_____

Policy Holder Social Security #:_____ Policy Holder Date of Birth:_____

Policy Holder Relationship to Patient:_____

EMPLOYMENT INFORMATION

Guarantor Employer:_____ Telephone:_____

Spouse's Employer:_____ Telephone:_____

Have you seen a urologist in Northwest Arkansas? Yes__ No__ Name:_____

If Yes, approximately how long ago? _____

INSURANCE AUTHORIZATION AND CONSENT FOR EXAMINATION (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE NORTHWEST ARKANSAS UROLOGY ASSOCIATES TO FURNISH MY INSURANCE COMPANY OR COMPANIES, MY ATTORNEY, OR MY PHYSICIAN ANY AND ALL INFORMATION THEY MAY REQUIRE CONCERNING MY CASE. I HEREBY ASSIGN TO THE CLINIC ALL PAYMENTS FOR MEDICAL SERVICES, SHOULD IT DESIRE TO TAKE SUCH ASSIGNMENT. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. I FURTHER AUTHORIZE THE DOCTORS AND STAFF OF NORTHWEST ARKANSAS UROLOGY ASSOCIATES TO EXAMINE ME AND PERFORM ANY SERVICES NORMALLY ASSOCIATED WITH MEDICAL CARE.

SIGNED:_____ DATE:_____

Northwest Arkansas Urology Associates

Patient Financial Policy

Please Read Carefully

Welcome to our practice! In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions regarding this policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your treatment.

- **PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.** Your health insurance policy is a contract between you and your insurance company. In many instances, the doctor is not involved. If you have questions about your responsibility, please ask to speak with the insurance coordinator or the office coordinator PRIOR to your visit with the doctor.

- **UNINSURED PATIENTS MAY BE REQUIRED TO MAKE A DEPOSIT AT INITIAL AND SUBSEQUENT VISITS.**

- We have made prior arrangements with many health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will require you to pay your authorized **co-payment, deductible, or co-insurance** at the time of service. We will collect the co-payments as soon as you arrive for your appointment. We will collect the estimated portion of your deductible and co-insurance as you check out. Those amounts are based on the services you received during your visit.

- It is the patient's responsibility to know if our practice is in network with their health plan, and what benefits are covered on their health plan.

- If you have a health plan that we do not have a prior agreement with, we will prepare the claim for you on an unassigned basis. This means that your carrier will send the payment directly to you. In this instance, our charges for your care and treatment will be due at the time of the service.

***For the following items, please indicate that you understand by printing your initials*:**

_____ In order to provide the best possible service and availability to all of our patients, we need to know **as soon as possible** (at least 24 hours prior to the scheduled time) if you need to cancel or reschedule your appointment. **If you miss your appointment without notifying us beforehand, you may be billed for the time scheduled.**

_____ Not all health plans are the same nor do they all cover the same services and supplies. In the event that your health plan determines a service or supply to be **"not covered,"** you will be responsible for the complete charge for that particular service. Payment is due upon receipt of a statement from our billing service. Payment for certain supplies will be required at the time of the visit (e.g., catheters, leg bags, gauzes, lubricants, etc.).

_____ You will be charged a minimum of $30.00 for the processing of forms (e.g., disability forms, life insurance info, FMLA, etc.) and up to $50 for copying/faxing/mailing medical records. In most instances, your insurer does not cover these charges. You may also be charged up to $95.00 for telephone consultations with your doctor. Those calls are not covered by most health plans.

_____ There will be a $25.00 charge for returned checks.

_____ Patient balances older than 90 days will be eligible for collections.

I have read and understand the financial policy of Northwest Arkansas Urology Associates and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by the practice.

_____ _____ _____

Signature Print Date

Northwest Arkansas Urology Associates
Advanced Technology and Treatment. For You.

Ph 479.521.8980 Fx 479.521.1088
www.nwaurology.com
5401 Willow Creek Dr. • Springdale, AR 72762

Chad E. Brekelbaum, MD • Nirmal K. Kilambi, MD, FACS • Michael R. Wilson, MD

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

In the space provided below, please list all individuals that we may speak with regarding your healthcare information (i.e. appointments, finances, refills, procedures, lab results). We will not be able to speak with them if they are not listed. You may change this list at any point by providing a written request.

I, _____, authorize Northwest Arkansas Urology Associates, PLLC, to verbally release my information to the individuals listed below (this does not include healthcare providers):

_____
_____
_____
_____
_____

_____

Northwest Arkansas Urology Associates, PLLC, may leave voice messages regarding my appointments, finances, refills, and test results at this phone #:_____.

_____

IF YOU <u>DO NOT AUTHORIZE ANYONE</u> TO ACCESS ANY OF YOUR HEALTHCARE INFORMATION (I. E. APPOINTMENT TIMES, FINANCIAL INFORMATION, RE-SCHEDULING) PLEASE PRINT BELOW:

I, _____, <u>do not authorize</u> Northwest Arkansas Urology Associates, PLLC, to verbally release any of my healthcare information (this includes, but is not limited to, information regarding: appointments, finances, refills, and test results).

_____

Patient or Authorized Personnel Signature _____

This authorization is valid for one year from this date _____.