UrologicSpecialists of Northwest Indiana

400 W. 84th Drive, Merrillville, IN 46410
2211 Main St, Ste. 1B, Highland, IN 46322
1500 Lake Park Ave., Ste. 203, Hobart, IN 46342
1461 W. Morthland Dr.Ste.A , Valparaiso, IN 46385

FEMALE PATIENT INFORMATION		
Last, First, MI	*Date of Birth*	*Referring Physician*
Chief Complaint *(Reason for visit today)*		

ALLERGIES

Dye/Iodine	**Y**	**N**	Latex	**Y**	**N**
Penicillin	**Y**	**N**	Shell Fish	**Y**	**N**
Sulfa	**Y**	**N**	Cipro	**Y**	**N**
Macrobid	**Y**	**N**	Codeine	**Y**	**N**

Medication Allergies:

_____

_____

CURRENT MEDICATIONS

Drug Name _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Occupation: _____

Married?	**Y**	**N**		
Do You Smoke:	**Y**	**N**	How Much?	_____
Former Smoker:	**Y**	**N**	Year Quit?	_____
Drink Alcohol:	**Y**	**N**	How Much?	_____
Illicit Drugs:	**Y**	**N**	Names?	_____
				_____

SURGERIES

Type	Date (Year only)
_____	
_____	
_____	
_____	
_____	
_____	
_____	

PAST MEDICAL HISTORY

			Year Diagnosed
Cancer	**Y**	**N**	Type _____
Diabetes	**Y**	**N**	_____
Heart Failure	**Y**	**N**	_____
Heart attack	**Y**	**N**	_____
Asthma/COPD	**Y**	**N**	_____
Hypertension	**Y**	**N**	_____
Kidney stones	**Y**	**N**	_____
Afib/Pacemaker	**Y**	**N**	_____
Stroke	**Y**	**N**	_____
Artificial Knee	**Y**	**N**	_____
Artificial Hip	**Y**	**N**	_____
Artificial Valve	**Y**	**N**	_____
Colonoscopy	**Y**	**N**	Year:_____
Flu Vaccine	**Y**	**N**	Year:_____
Pneumonia Vaccine	**Y**	**N**	Year:_____
Number of Children:			
Vaginal delivery_____			C-Section_____
Breast Cancer	**Y**	**N**	
Ovarian Cancer	**Y**	**N**	

FAMILY HISTORY

			Family Member
Cancer (type)	**Y**	**N**	_____
Diabetes	**Y**	**N**	_____
Heart disease	**Y**	**N**	_____
Kidney stones	**Y**	**N**	_____
Stroke	**Y**	**N**	_____

URINARY INCONTINENCE IMPACT QUESTIONNAIRE

Check the number in each line that best describes how much your activities, relationships, and feelings are being affected by urine leakage over the past month.

Has urine leakage (incontinence) affected your:	Not at all	Slightly	Moderately	Greatly
Ability to do household chores (cooking, housecleaning, laundry)?	☐ 0	☐ 1	☐ 2	☐ 3
Physical recreation such as walking, swimming or other exercise?	☐ 0	☐ 1	☐ 2	☐ 3
Entertaining activities (movies, concerts, etc.)	☐ 0	☐ 1	☐ 2	☐ 3
Ability to travel by car or bus for more than 30 minutes from home?	☐ 0	☐ 1	☐ 2	☐ 3
Participation in social activities outside of the home?	☐ 0	☐ 1	☐ 2	☐ 3
Emotional health (nervousness, depression, etc.)?	☐ 0	☐ 1	☐ 2	☐ 3
Frustration levels?	☐ 0	☐ 1	☐ 2	☐ 3

PATIENT INFORMATION												
Last Name:					**First Name & Initial:**							
Patient's SSN:		**Sex:**	**M F**		**Date of Birth:**			**Marital Status:**		**Married / Single**		
Address:												
City:							**State :**			**Zip :**		
Primary Contact #:	☐	**Home Phone**		☐	**Work Phone**		☐	**Cell Phone**				
Email Address:						**Primary Care Physician:**						
Employer:					**Employer's Address:**							
Occupation:				**Employment Status:**		**Full-time / Part-time / Retired / Student**						
Spouse's Name:												
Spouse's Home Phone:			**Spouse's Work Phone:**			**Spouse's Cell Phone:**						
Preferred Language:			**Religion:**			**Place of Worship:**						
Ethnicity:	☐ **Yes, Hispanic or Latino**					☐ **No, Not Hispanic**						
Race:	**American Indian / Alaskan Native / Asian / Black or African American / Native Hawaiian or other Pacific Islander / White or Caucasian / Other / Do Not Wish to Answer**											
EMERGENCY CONTACT INFO												
Nearest Relative or Friend:						**Relationship :**						
Address:												
Primary Contact #:	☐	**Home Phone**		☐	**Work Phone**		☐	**Cell Phone**				

ACKNOWLEDGEMENTS

Authorization for Treatment – I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medications as deemed necessary or advisable. I hereby certify that I have read and fully understand this authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Information/Medical Record/Diagnosis – I hereby authorize the physician providing services and any other authorized person to release to authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation insurance company, or other category of third-party payer, the Social Security Administration under Title XVIII of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.

I give my permission to Urologic Specialists of NW Indiana and all clinical providers who have provided care to me, along with any billing service, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.

Authorization for Assignment of Benefits / Financial Obligation – In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit ePart B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full, my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to insufficient funds.

Co-Payments – I understand that if my medical insurance requires a co-pay or encounter fee, the payment is due AT TIME OF SERVICE.

No Show Policy – Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments, we have instituted a **$25.00 no show fee**. **You are required to give 24-hour advanced notice to cancel appointments. Failure to do so will result in a $25.00 fee charged to your account.**

By signing below, I acknowledge that I have read and understand this policy.

I give consent and authorization for the medical and staff of my physician's office to release information regarding my medical care to:

_____ _____

Name / Relationship Name / Relationship

I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Patient/Parent/Guardian_____ Date_____

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES:

_____ _____

Patient Signature Date Responsibility Party Signature Date

_____ _____

Witness Signature Date Relationship to Patient

Revised 6/25/2021