Willamette UROLOGY

Demographic Form

Today's Date ____/____/_____

Last Name _____ First Name _____ Middle _____ Nickname _____

Date of Birth ____/____/_____ Social Security Number _____ Age _____

Sex Assigned at Birth_____ Gender Preferred Pronoun_____

Home Address _____ Mailing Address _____

City _____ City _____

State _____ State _____

Zip _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address: _____ Would you like to enroll in our patient portal? ☐ Yes ☐ No

Race (Choose): ☐ White ☐ Hispanic ☐ African American ☐ Asian ☐ American Indian ☐ Hawaiian ☐ Other_____

Ethnicity (Choose): ☐ NOT Hispanic or Latino ☐ Hispanic or Latino **Preferred Language:** _____

Current Employer _____ Occupation _____

Referring Physician _____ Primary Care Physician _____

Name City Name City

Primary Pharmacy _____ 2nd Pharmacy _____

Name Street Location Name Street Location

RESPONSIBLE PARTY: (If different from patient, please circle one: Guardian / Guarantor / Spouse)

LEGAL NAME - Last Name _____ First Name _____ Middle _____

Date of Birth ____/____/_____ Social Security Number _____ Relationship to patient _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

EMERGENCY INFORMATION

Name of someone not living with you _____ Relationship to patient _____

Address _____ Phone _____

PRIMARY HEALTH INSURANCE

Insured's Name _____ **Date of Birth** ____/____/_____

Insurance Carrier _____ Relationship to patient _____

Insurance Address _____ Insurance phone _____

Member Number _____ Group Number _____ Employer _____

SECONDARY HEALTH INSURANCE

Insured's Name _____ **Date of Birth** ____/____/_____

Insurance Carrier _____ Relationship to patient _____

Insurance Address _____ Insurance phone _____

Member Number _____ Group Number _____ Employer _____

Willamette Urology - History Form

Today's Date:____/____/_____

Last Name:_____ First Name:_____ Date of Birth:_____/____/_____

CHIEF COMPLAINT: What is the Main Reason for your visit today? (Describe your problem in detail)

_____

_____

SOCIAL HISTORY:

Are you married? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ No ☐ Yes -#____ **Are you pregnant?** ☐ **Yes** ☐ **No**

Tobacco use? ☐ **Yes** ☐ **Never** ☐ **Former** **Alcohol use?** ☐ **Yes** ☐ **No** **Caffeine use?** ☐ **Yes** ☐ **No**

Type: ☐ Chewing ☐ Cigar ☐ Cigarettes ☐ Pipe Amount: _____ Amount Daily:_____

Packs/Day:_____ Age Quit:_____ Freq.:_____ Type: _____

Do your beliefs ALLOW you to receive blood or blood products? ☐ **Yes** ☐ **No**

Have you received the pneumonia vaccine? ☐ **Yes** ☐ **No** **Estimated date/year vaccinated** _____

FAMILY HISTORY: Please check all serious illnesses in your immediate family -mother, father, sister, brother

☐ BPH (benign prostate hypertrophy) ☐ Kidney Disease

☐ Cancer /type: _____ ☐ Urolithiasis (kidney stones)

If family member has died, please indicate cause and age at death: Mother _____ Sister _____ Father _____ Brother _____

PAST MEDICAL HISTORY - Please check YES if you currently have or you have a past history of:

YES	CARDIOVASCULAR:	
☐	High Blood Pressure	(I10)
☐	Chest Pain (Angina)	
☐	History of Heart Attack	
☐	Congestive Heart Failure	(I50.9)
☐	Heart Murmur or Valve Disorder	
☐	Pacemaker Type?	
☐	Irregular Heartbeat/Palpitations	
☐	Phlebitis / Deep Vein Thrombosis	
☐	Swelling of Ankles (Edema)	
☐	Rheumatic Fever	
☐	Stroke (Cerebrovascular Accident)	

YES	GENERAL:	
☐	AIDS/HIV	
☐	Alzheimer's	
☐	Anemia	
☐	Arthritis: Rheumatoid (M06.9) / Osteo	(M19.90
☐	Asthma / Wheezing	
☐	Cancer Type?	(C80.1)
☐	Depression	
☐	Diabetes ☐Type 1 ☐Type 2	(E11.9)
☐	COPD / Emphysema	(J44.9)
☐	Gout	
☐	Hepatitis ☐B ☐C	

YES	GENERAL:
☐	Liver Disease
☐	Seizures
☐	Sleep Apnea (circle) CPAP / BiPAP
☐	Thyroid Disorder
☐	Ulcers

	GENITOURINARY:
☐	Painful Urination (Dysuria)
☐	Blood in Urine (Hematuria)
☐	Urinary Frequency
☐	Kidney Disease
☐	Urolithiasis (Kidney Stones)
☐	Incontinence (Leak Urine)

Other Past Medical History: _____

List any PAST SURGERIES and when they occurred (example: vasectomy) - attach separate sheet if necessary

Surgery: _____ Year: _____ Surgery: _____ Year: _____

Surgery: _____ Year: _____ Surgery: _____ Year: _____

REVIEW OF SYSTEMS - Please check YES if you currently have or you have a past history of:

YES	CONSTITUTIONAL:
☐	Fatigue
☐	Recent Fever (100 F or above)
☐	Decreased Appetite
☐	

YES	MUSCULOSKELETAL:	
☐	Bone/Joint Symptoms	
☐	Osteoporosis	(M81.0 w/o fracture)

	HEENT:
☐	Vision Loss

YES	REPRODUCTIVE:
☐	Vaginal Discharge
☐	Cramps/Painful Menstruation
☐	Abnormal/Prolonged Menstruation
☐	Penile Discharge

	GASTROINTESTINAL:
☐	Abdominal Pain
☐	Constipation
☐	Diarrhea
☐	Vomiting

	NEUROLOGICAL:
☐	Dizziness
☐	Numbness or Tingling

	HEMATOLGIC:
☐	Easy Bleeding (bleeding problem)
☐	Easy Bruising

Willamette Urology - Medication & Allergy List

Today's Date: ____/____/_____

Last Name: _____ First Name: _____ Date of Birth: ____/____/_____

ALLERGIES - Please list any medicine, food, environmental, latex or x-ray dye material allergies

☐ **Check here if you have NO KNOWN ALLERGIES**

_____

_____

_____

MEDICATIONS - Please list all medications you currently take. Attach another sheet if necessary

☐ **Check here if you are taking NO MEDICATIONS**

Prescription Medications	Dose (example: 20mg)	Frequency (example: 1 a day)
Herbal Supplements / Vitamins (example: Vitamin C)		Frequency (example: 1 a day)
Over The Counter (example: Aspirin / Tylenol)		Frequency (example: as needed)

Willamette UROLOGY

ACKNOWLEDGMENT AND CONSENT

Last Name: _____ First Name: _____ Date of Birth: ____/____/_____

I understand that Willamette Urology, P.C. will use and disclose health information about me. I understand that my health information may include information both created and received by the practice. It may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand that I have the right to receive and review a written description of how Willamette Urology, P.C. will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, physicians and other personnel of Willamette Urology, P.C. and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of Willamette Urology, P.C. **Notice of Privacy Practices is available in the lobby and on our web site at www.WillametteUrology.com**.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Willamette Urology, P.C. is not required by law to agree to such requests.

I understand Willamette Urology, P.C. is restricted in discussing my health information with family members or friends without written permission. I hereby authorize Willamette Urology, P.C. to release medical information regarding myself to the person(s) listed below. I understand this information may include diagnosis, treatment and lab or x-ray results.

CONSENT TO RELEASE INFORMATION – PERSON(S) AUTHORIZED TO RECEIVE INFORMATION:

_____

Please Print Name Relationship

_____

Please Print Name Relationship

May we leave a detailed voicemail on your answering machine at home? ☐ **Yes** ☐ **No**

May we leave a detailed voicemail on your answering machine on your cell phone? ☐ **Yes** ☐ **No**

I agree that I have reviewed and understand the information above and that I am free to take a copy of the Notice of Privacy Practices available at the reception counters and online at www.WillametteUrology.com.

_____

PATIENT SIGNATURE **DATE**

2973 12th Street SE - Salem, Oregon 97302 - Phone (503) 561-7100 - Fax (503) 561-7124

Willamette UROLOGY

PATIENT FINANCIAL POLICY

Print Patient Name: _____ Date of Birth: _____

Thank you for choosing us as your health care provider. We are committed to providing you with quality medical care. Please understand that payment for your bill is considered part of your care plan. We ask that you read and sign this Patient Financial Policy at your visit today.

1. Insurance is billed as a courtesy when you provide us with current insurance information and sign our Acknowledgment and Consent form. If you do not present a current insurance card at the time of visit, or do not sign our Acknowledgment and Consent form, you will be billed directly for the provided services. Please be advised that insurance is a contract between you and your insurance carrier. You are responsible for payment of your account.

2. Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered by your plan, or how it will be covered by your plan. We recommend that you contact your insurance carrier with any questions that you may have regarding your coverage for these services. You are responsible for knowing the details / rules of your health plan.

3. In the absence of insurance coverage, a $100 deposit is required at time of service. If you are unable to pay this deposit, upon request, a Financial Assistance Application will be given / mailed to you. Completed applications will be reviewed and you will be notified in writing of any amount the physician will write off. Reduction in your financial responsibility will be based on your ability to pay and not your willingness to pay.

4. If you have a balance due on your account, we will send you a bi-weekly statement. The balance on your statement is due and payable when the statement is issued and is past due if not paid within 30 days. If you are unable to pay in full you should contact our office to set up a payment plan. Dishonored checks will be charged $35.00.

5. If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all collection costs which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorney fees including court costs.

6. You understand if this account is submitted to a collection agency or attorney, is litigated in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

I HAVE READ THIS FINANCIAL POLICY AND UNDERSTAND THAT REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE, I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT. I UNDERSTAND THAT DELINQUENT ACCOUNTS WILL BE ASSIGNED TO A CREDIT REPORTING COLLECTION AGENCY. IF IT BECOMES NECESSARY TO PROCEED WITH COLLECTIONS, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEY FEES.

_____ _____

Patient / Guarantor Signature Date

_____ _____

Print Patient / Guarantor Name Relationship to patient if not the patient