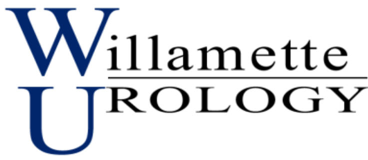


Demographic Form

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:	YES	GENERAL:	YES	GENERAL:
☐	High Blood Pressure (I10)	☐	AIDS/HIV	☐	Liver Disease
☐	Chest Pain (Angina)	☐	Alzheimer's	☐	Seizures
☐	History of Heart Attack	☐	Anemia	☐	Sleep Apnea (circle) CPAP / BiPAP
☐	Congestive Heart Failure (I50.9)	☐	Arthritis: Rheumatoid (M06.9) / Osteo (M19.90	☐	Thyroid Disorder
☐	Heart Murmur or Valve Disorder	☐	Asthma / Wheezing	☐	Ulcers
☐	Pacemaker Type?	☐	Cancer Type? (C80.1)		**GENITOURINARY:**
☐	Irregular Heartbeat/Palpitations	☐	Depression	☐	Painful Urination (Dysuria)
☐	Phlebitis / Deep Vein Thrombosis	☐	Diabetes Type 1 Type 2 (E11.9)	☐	Blood in Urine (Hematuria)
☐	Swelling of Ankles (Edema)	☐	COPD / Emphysema (J44.9)	☐	Urinary Frequency
☐	Rheumatic Fever	☐	Gout	☐	Kidney Disease
☐	Stroke (Cerebrovascular Accident)	☐	Hepatitis B C	☐	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:	YES	MUSCULOSKELETAL:	YES	REPRODUCTIVE:
☐	Fatigue	☐	Bone/Joint Symptoms	☐	Vaginal Discharge
☐	Recent Fever (100 F or above)	☐	Osteoporosis (M81.0 w/o fracture)	☐	Cramps/Painful Menstruation
☐	Decreased Appetite		**HEENT:**	☐	Abnormal/Prolonged Menstruation
☐		☐	Vision Loss	☐	Penile Discharge
	GASTROINTESTINAL:		**NEUROLOGICAL:**		**HEMATOLGIC:**
☐	Abdominal Pain	☐	Dizziness	☐	Easy Bleeding (bleeding problem)
☐	Constipation	☐	Numbness or Tingling	☐	Easy Bruising
☐	Diarrhea				
☐	Vomiting				

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**

____

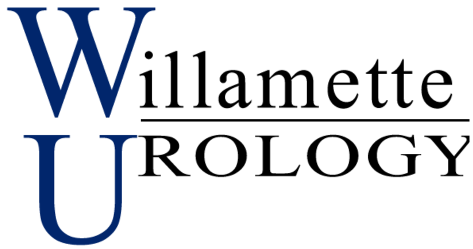
____

____

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)



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

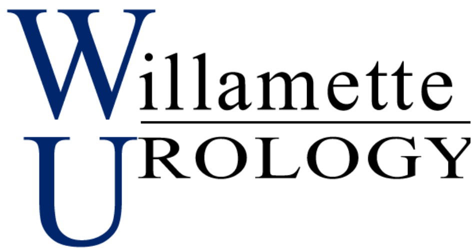
May we leave a detailed voicemail on your answering machine at home? Yes No

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**



PATIENT FINANCIAL POLICY

____

Print Patient Name: ________________________________ Date of Birth: _________________

Thank you for choosing Willamette Urology as your healthcare 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, 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. It is important for you to understand that most insurance policies will not cover all of our charges. We may require you to make some type of payment before services can be provided. Typically, the payments are called co-payments, co-insurance or deductibles. These amounts are put in place by your insurance carrier, not our office. We will do our best to notify you ahead of time whenever possible. Any amounts quoted prior to the services being provided are only estimates and may be adjusted once the services have been provided, and insurance payments received.
3. Referrals and prior authorizations may be required by your insurance policy. We will do our best to obtain these; however, it is your responsibility to ensure these are in place prior to receiving services
4. 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. You have up to 90 days from the date of service to complete your application.
5. 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 may enroll in an in-house payment arrangement up to three months, which will have a standard minimum of $25.00. Dishonored checks will be charged $35.00.
6. If we have to refer your account to a collection agency, you agree to pay all collection costs that are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorney fees, including court costs.
7. You grant permission and consent to Willamette Urology and its agents, assignees, and contractors (which may include third-party debt collectors for past due obligations):

   (1) to contact you by phone at any number associated with you, whether provided by you or obtained on its own;
   (2) to leave messages for you and include in any such messages the amounts owed by you;
   (3) to send you text messages or emails using any email address or phone number associated with you, whether provided by you or obtained on its own; and
   (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto-dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to you regarding your account.

8. You agree to provide updated contact information in an effort to avoid unintended disclosures of your information, and you accept and acknowledge that Willamette Urology and its agents, assignees, and contractors (which may include third-party debt collectors for past due obligations) will treat any email address or phone number obtained as your private email or phone number that is not accessible by unauthorized third parties.

9. You understand that communications may result in charges to you by your mobile service provider and are not encrypted.

10. You understand that communication attempts will be made to your cellular phone during permitted calling hours based upon the time zone affiliated with the cellular phone number provided unless notified otherwise.

11. 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

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