

WELCOME TO UROLOGY GROUP OF NEW MEXICO

PLEASE BRING THE FOLLOWING TO YOUR APPOINTMENT AND PRESENT IT AT CHECK-IN, OR YOUR APPOINTMENT MAY NEED TO BE RESCHEDULED.

- **Completed New Patient forms, which are enclosed.**
- **Any lab, ultrasound exams and/or x-rays pertinent to your visit with us:
You will need to bring the films as well as the radiologist's reports. Ask for your films to be checked out to you for your doctor's appointment and copies of the reports.**
- **Most recent PSA:
Males forty years or older must have a current PSA if you have not had one in the last 3-6 months.**
- **A urine specimen for most appointments is required:
Be prepared to provide us with a urine specimen upon arrival. If you have difficulty providing a urine sample in the office, stop by and we can provide a cup to obtain a specimen at home. Please refrigerate sample until appointment time.**
- **Your medications:
We need to be aware of the name, the number of times a day and milligram dosage of your medications. Please bring a list of medications or the actual medication with you.**
- **A referral from your doctor if required by your Health Plan:
You will be financially responsible for all services rendered without a referral. If your Health Plan requires a referral and you do not have one at the time of your appointment, we will be happy to see you, however, charges will be due at time of service.**
- **Your Health Plan ID card:
If we are not participating providers with your Health Plan, payment in full is due at the time of service. If you are not sure, please call you Health Plan prior to your appointment.**
- **Payment for services rendered not covered by Health Plan:
We accept cash, check, VISA, Mastercard, Discover, and American Express.**

Thank you for attending to the above issues. This will allow you to get as much information, value and time saving from your visit with the doctor. Many of the above requirements are by HMO's and Managed Care.

If you have any questions regarding your appointment, feel free to call us at (505) 872-4091.

PLEASE PRINT AND FILL OUT COMPLETELY

NAME: LAST FIRST MI PRIMARY CARE PHYSICIAN

M F
AGE SEX DATE OF BIRTH SOCIAL SECURITY NUMBER REFERRED BY: DR., OTHER

ADDRESS: STREET APT # CITY STATE ZIP HOME PHONE CELL PHONE

EMPLOYER: OCCUPATION:

ADDRESS: WORK PHONE:

MARITAL STATUS: S M W D SPOUSE'S NAME:

SPOUSE'S EMPLOYER: WORK PHONE:

EMERGENCY CONTACT: HOME PHONE:

RELATIONSHIP: WORK PHONE:

(RESPONSIBLE PARTY INFORMATION IF DIFFERENT THAN ABOVE)

NAME SOCIAL SECURITY NUMBER DATE OF BIRTH

RELATIONSHIP TO PATIENT: HOME PHONE:

ADDRESS:

EMPLOYER: OCCUPATION:

EMPLOYER'S ADDRESS: WORK PHONE:

PRIMARY INSURANCE SECONDARY INSURANCE

INSURANCE NAME: INSURANCE NAME:

POLICYHOLDER: POLICY HOLDER:

ID #: ID #:

GROUP #: GROUP #:

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE *UROLOGY GROUP OF NEW MEXICO, P.C.* TO FURNISH INFORMATION TO MY PRIMARY/REFERRING PHYSICIAN AND/OR TO INSURANCE CARRIERS CONCERNING MY DIAGNOSIS AND TREATMENTS, INCLUDING MY HIV STATUS.

SIGNATURE: DATE:

ASSIGNMENT OF BENEFITS AND AGREEMENT TO PAY:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO *UROLOGY GROUP OF NEW MEXICO, P.C.* FOR THE SERVICES RENDERED BY THEM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE DOCTORS FOR CHARGES NOT COVERED BY THIS AUTHORIZATION. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE AND THAT IT IS CUSTOMARY TO PAY FOR ALL SERVICES WHEN RENDERED, UNLESS ARRANGEMENTS ARE MADE IN ADVANCE.

SIGNATURE: DATE:

PAST MEDICAL HISTORY

Patient name: _____

Date: _____

SOCIAL HISTORY:

HOW MUCH PER DAY DO YOU USE THE FOLLOWING?

Tobacco _____ Alcohol _____ Coffee/Tea _____

Do you have a history of tobacco use? _____ Number of years _____ Packs per day _____

DIETS:

ARE YOU ON ANY SPECIAL DIETS? _____

Your FAMILY HISTORY:

HAVE ANY OF **YOUR BLOOD RELATIVES** EVER HAD ANY OF THE FOLLOWING?

Bladder Cancer Tuberculosis Stroke Gout
 Prostate Cancer Heart Disease Bleeding Disorder Diabetes
 Testicular Cancer Heart Attack High Blood Pressure
 Other Cancer (Describe): _____

ALLERGIES:

LIST ALL DRUG ALLERGIES: _____ NONE ?

LIST ALL HOSPITALIZATIONS AND SURGERIES:

(include childhood hospitalizations and surgeries)

_____ Date: _____
 _____ Date: _____
 _____ Date: _____
 _____ Date: _____
 _____ Date: _____

LIST ANY OTHER MEDICAL ILLNESSES (and how long you have had them):

Illness: _____ How long? _____
 Illness: _____ How long? _____
 Illness: _____ How long? _____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING CANCER? YES NO

If yes, what type? _____

# Answer	Level of service	Initial	Date
0	1 or 2		
1 - 2	3		
3	4 or 5		

REVIEW OF SYSTEMS

Name: _____

Date: _____

Do you now or have you had any of the following problems? Circle Y for Yes or N for No.

Please explain any Yes answers in the space provided.

<p><u>GENERAL:</u> Weight loss Y N Recent fever Y N</p>	<p><u>GASTROINTESTINAL:</u> Recent indigestion Y N Recent heartburn Y N Abdominal pain Y N Recent nausea Y N Recent vomiting Y N Gall stones Y N Ulcer Y N Severe constipation Y N Recent Diarrhea Y N Bloody stools Y N Black stools Y N Hemorrhoids Y N Hepatitis Y N Jaundice Y N</p>
<p><u>ENDOCRINE:</u> Thyroid trouble Y N Diabetes Y N</p>	<p><u>HEMATOLOGICAL:</u> Anemia Y N Bleeding problems Y N Blood clots Y N Gout Y N</p>
<p><u>RESPIRATORY:</u> Asthma Y N Recent coughing Y N Recent coughing up phlegm Y N Coughing blood Y N Shortness of Breath Y N</p>	<p><u>DERMATOLOGICAL:</u> Recent rash Y N Recent itching Y N</p>
<p><u>CARDIOVASCULAR:</u> High blood pressure Y N Heart attack Y N Heart murmur Y N Rheumatic fever Y N Ankle swelling Y N Chest pains Y N Heart Palpitations Y N Leg muscle pain when walking Y N</p>	<p><u>UROLOGICAL:</u> Kidney stones Y N Bloody urine Y N Bladder infections Y N Kidney infections Y N Burning during urination Y N Frequent urination Y N Urine retention Y N</p>
<p><u>NEUROLOGICAL:</u> Convulsions Y N Stroke Y N Paralysis Y N Seizures Y N Head Injuries Y N Back injuries Y N Back surgery Y N</p>	<p><u>PSYCHOLOGICAL:</u> Satisfied with life Y N Depression Y N Considered suicide Y N</p>
<p><u>FEMALE GENITAL:</u> Menstrual problems Y N Vaginal discharge Y N Breast lump Y N</p>	<p><u>OTHER:</u> Sexual problems Y N Tired Y N Nervousness Y N Venereal disease Y N</p>
<p><u>MUSCULOSKELATAL :</u> Arthritis Y N Joint pain Y N Neck pain Y N Back pain Y N</p>	

#Answer	Level of service
0-1	1 or 2
2-9	3
10+	4 or 5

Init	Date

UROLOGY GROUP OF NEW MEXICO,PC

FINANCIAL PAYMENT POLICY

REGARDING INSURANCE. The doctor's service is provided directly to you and you are responsible for payment of these services. We cannot provide service on the assumption that charges will be paid by your insurance company. If we are not participating providers with your insurance company, we require payment be made at the time services are rendered. As a courtesy to our patients we will submit a paid claim to your insurance company for you.

Our office participates with Medicare senior plans and many managed care insurance companies. Should your insurance coverage be with one or more of these companies, we will bill your insurance company based on the guidelines of our contract. Co-payments and deductibles that have not been satisfied are required at the time services are rendered. It is your responsibility to obtain a proper referral from your primary care physician, if required by your insurance plan. Charges may be your responsibility if you do not secure a proper referral for the services provided.

If a surgical procedure is performed, our office will bill your insurance company directly and withhold any action for forty-five days. However, if your insurance company has failed to pay within forty-five days, we will expect you to pay the full balance due and then you collect from your insurance company.

Informing our patients about our financial policy assists us in providing the best services to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please contact our billing staff or manager.

WE ARE HERE TO HELP YOU!

I hereby understand the financial policy of the office:

Signature

Date