

WELCOME TO UROLOGY GROUP OF NEW MEXICO

THANK YOU FOR ATTENDING TO THE ISSUES BELOW. THIS WILL ALLOW YOU TO GET AS MUCH INFORMATION, VALUE AND TIME SAVINGS FROM YOUR DOCTOR VISIT AS POSSIBLE. MANY OF THESE ITEMS ARE THE REQUIREMENT OF YOUR INSURANCE COMPANY, HMO'S AND MEDICARE. PLEASE BRING THESE ITEMS TO YOUR APPOINTMENT AND PRESENT THEM 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 radiologists 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 current PSA if you have not had one in the last 3-6 months. Please check with our office to see if your insurance will cover running the test here at the time of your appointment.
- 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 the sample until appointment time.
- Your medications**
We need to be aware of the name, the number of times day, and the milligram dose of your medications. Please bring a list of your medications or the actual medications with you. Please include all vitamin and herbal supplements.
- 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 the time of service.
- You 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 your Plan prior to your appointment.
- Payment for services rendered not covered by your Health Plan**
We accept cash, check, VISA, MasterCard or Discover.

As a courtesy to our physicians, staff, and other patients waiting for appointments, **Please call us at least 24 hours in advance** of any appointments that you can not keep. If you have any questions regarding your appointments, feel free to call us at 505-872-4091.

PLEASE PRINT AND FILL OUT COMPLETELY

NAME: LAST FIRST MI PRIMARY CARE PHYSICIAN

AGE M F SEX DATE OF BIRTH SOCIAL SECURITY NUMBER REFERRING PHYSICIAN (IF DIFFERENT)

ADDRESS: STREET APT# CITY STATE ZIP HOME PHONE

EMPLOYER: OCCUPATION:

WORK 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: SOC. SEC. #

RELATIONSHIP TO PATIENT: HOME PHONE:

ADDRESS:

EMPLOYER: OCCUPATION:

EMPLOYERS ADDRESS: WORK PHONE:

PRIMARY INSURANCE COMPANY:

ID #: GROUP # POLICYHOLDER:

SECONDARY INSURANCE COMPANY:

ID #: GROUP # POLICYHOLDER:

AUTHORIZATION TO RELEASE INFORMATION

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

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. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. 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 _____

If you ever used tobacco: Number of years? _____ Packs per day? _____ Quit When? _____

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></p> <p>Weight loss Y N Recent fever Y N</p> | <p><u>GASTROINTESTINAL:</u></p> <p>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></p> <p>Thyroid trouble Y N Diabetes Y N</p> | <p><u>HEMATOLOGICAL:</u></p> <p>Anemia Y N Bleeding problems Y N Blood clots Y N Gout Y N</p> |
| <p><u>RESPIRATORY:</u></p> <p>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></p> <p>Recent rash Y N Recent itching Y N</p> |
| <p><u>CARDIOVASCULAR:</u></p> <p>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></p> <p>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></p> <p>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></p> <p>Satisfied with life Y N Depression Y N Considered suicide Y N Tired Y N Nervousness Y N</p> |
| <p><u>FEMALE GENITAL:</u></p> <p>Menstrual problems Y N Vaginal discharge Y N Breast lump Y N</p> | <p><u>Sexual:</u></p> <p>Sexual Problems Y N Genital Herpes/ Sores Y N Sexual Abuse Y N Impotence Y N Premature Ejaculation Y N</p> |
| <p><u>MUSCULOSKELATAL :</u></p> <p>Arthritis 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 |
|------|------|
| | |
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