ADULT & PEDIATRIC UROLOGY

537 MURPHY RD. SUITE B MEDFORD, OR 97504
ADULT AND PEDIATRIC UROLOGY
PH: 541 772 6600 FX: 541 779 1266

Patient Name: _____ Guardian Name: _____
Appointment date: _____ Check in time: _____

Please complete the attached registration forms, along with your past medical history
Mail completed paperwork to our office to expedite appointment registration. Forms can be brought to appointment completed if not enough time to mail back.

- Day of appointment: *Please check in 30 minutes early*, this is required for all Initial New Patient consults (see check in time above)
  ~Provide insurance cards ~Provide copy of current medication list
  ~Leave urine sample ~We will collect your Copay at check-in

***Checking in early for appointment allows our office to update your chart & get you ready to see the doctor at your *Scheduled Appointment Time* *(Checking in late could cause appointment re-schedule)**

Managed Care: If your insurance requires a referral from a primary care physician or the referring physician, please be advised that it is your responsibility to contact your primary care physician or referring physician for your insurance prior authorization to be submitted prior to the appointment in our office. This process assures that the services provided are paid by your insurance company and not forwarded to patient responsibility.

Private Pay: Patients should be prepared to pay $150 at your initial appointment and sign a private pay form noting the amount that will be paid monthly until account is paid in full. A 10% discount is applied to all dates of service for private pay patients only.

Medicare: We will gladly submit your claim to Medicare. You will be required to sign an Advance Beneficiary Notice (ABN) that Medicare may not pay for all the health care costs your physician finds medically necessary. The purpose of the ABN is to help you make an informed choice about whether you want to receive these items or services, knowing that you will have to pay for them yourself or the charges will have to be submitted to another insurance company, i.e. leg bags, Foley catheters, certain medications, etc. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them. If you're not sure what Medicare benefits are covered, please contact Medicare or review your policy benefits. If you have any questions, please see our business office. We would be happy to assist you.

Oregon Health Plan (OHP): If you have coverage through Oregon Health Plan you must present a current card and copay, if required, at the time of your visit or your appointment will be rescheduled. If your care is managed, we need to be made aware of this when your appointment is scheduled. This will allow us time to get the necessary insurance authorization in place from your primary care doctor prior to your visit. If insurance prior authorization is not received prior to your appointment, appointment will be rescheduled.

Workers Compensation: If you are seen for a work-related injury you must present the following: Name and address of worker's compensation carrier, date of injury, state of injury and active claim number.

Other Instructions:_____

If you have any questions, please call us at 541-772-6600

ERIC L. MARTIN, M.D. F.A.C.S., P.C.
Physician and Surgeon
Diplomate American Board of Urology

PATIENT INFORMATION

(Completion of this information in its entirety is required at time of visit) (Dr. Eric L. Martin)

Today's date: _____ Last Name: _____ First Name: _____ Middle____

Date of Birth: _____ Age _____ Social Security # _____-____-_____

Billing Address: _____ City _____ State _____ Zip _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Work Phone (_____) _____-_____.

Height: _____ Weight _____ Claustrophobic? Yes_____/ No_____ Race _____ Ethnicity _____

Prim Language _____ Marital Status _____ Spouse Name _____

Employer _____ Spouse Employer _____

Email Address _____

*****I authorize that my medical care and billing may be discussed with my spouse/relative/friend****
Yes____/ No____ (Give name authorized Individual_____)

*****If someone other than the PATIENT is responsible for payment****, complete the following:

Name of responsible party: _____ Relationship to patient: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

****Emergency Contact***

Relative to contact (other than spouse) _____ Phone (_____) _____-_____

How do you intend to pay? Insurance_____ Private Pay _____ Other _____

Primary Insurance: _____ Phone (_____) _____-_____

Name of Insured: _____ (if not patient) DOB___/___/_____ SS#_____-____-_____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Phone (_____) _____-_____ Policy #: _____

Patient Signature: _____ Date: _____

Or Guardian: _____ (Relation to patient) _____

**Would you like a copy of our Notice of Privacy Practices (NPP) Yes_____ No_____

***PLEASE NOTE: I UNDERSTAND THAT IF I HAVE AN HMO TYPE OF INSURANCE AND I DO NOT HAVE AN APPROPRIATE REFERRAL IN PLACE FROM MY PRIMARY CARE PHYSICIAN, THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED AT THIS OFFICE. ANY CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE, AS ARE UNCOVERED SERVICES, UNLESS ARRANGEMENTS HAVE BEEN MADE WITH THE BUSINESS OFFICE. "IN THE EVENT LEGAL ACTION IS NECESSARY TO COLLECT ANY AMOUNTS THAT REMAIN UNPAID, THEN I UNDERSTAND THAT I WILL HAVE TO PAY ANY REASONABLE ATTORNEY FEES INCURRED."*

MUST SIGN REVERSE SIDE FOR HIPAA COMPLIANCE CONSENT FORM AND AUTHORIZATION. THANK YOU!

HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (Insurance Company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____ (day) of (month) _____, 20____

Print Patient Name_____

Relationship to Patient_____

Signature_____

Name: _____DOB_____ Date: _____Acct #_____E

Urologist: Eric L. Martin MD, FACS PC

Referring Doctor: _____ **Family Doctor:** _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____

What improves or worsens the problem/pain? _____

Are there any symptoms that go along with the problem/pain? _____

Is the problem/pain continuous or does it come and go? _____

Describe the pain (sharp/dull, etc.) _____

Have you tried any medicine/treatment for this problem/pain? _____

CURRENT MEDICATIONS – Please list ALL medications you are currently taking including over the counter meds

Drug Name:	Strength:	Directions/How you take it: (**Attach list if necessary**)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY NAME: _____ **City:** _____ **Phone #:** _____

ALLERGIES – Please list ALL types (Drug, seasonal, pets, environmental foods)

_____ _____ _____ _____ _____

___By what method did you choose our practice:

_____Referring Physician _____Friend _____Yellow Pages _____Insurance Company _____Other

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years

_____ Single _____Married _____Separated _____Divorced _____Widowed _____Life Partner ____Common Law Spouse

Dependents: Please indicate # of each, if you have:

_____Sons _____Daughters _____Stepchildren _____Adopted _____Foster _____Parents _____Grandparents

Occupation: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other

Hobbies: Please circle any that apply to you:

None, Golf, Tennis, Computers, Basketball, Football, Swimming, Soccer, Baseball

Alcohol Consumption:

_____None _____Yes Occasional/Social # of drinks per day _____

Tobacco per day:

_____None _____Yes #_____Packs/day _____Cigarettes/day _____Smokeless Tobacco

If you previously stopped, When? _____

Recreational Drugs: _____None If yes, please list: _____

Name: _____DOB_____Date: _____

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular
Anemia
Angina
Anorexia
Aortic Aneurysm
Aortic Regurgitation
Aortic Stenosis
Arrhytmia
Atrial Fibrillation
Bleeding Disorder
Cardiomyopathy
Cerebrovascular Disease
Claudication
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Enlarged Heart
Heart Attack
Heart Block
Heart Disease
Heart Murmur
Heart Valve Problem
Hemophilia
Hypertension, well controlled
Hypertension, progressive
Hypertension, severe
Leukemia
Mitral Insufficiency
Mitral Stenosis
Mitral Valve Prolapse
Rheumatic Fever
Sickle Cell Anemia
Stroke
Thrombophlebitis
Varicose Veins
Ventricular Arrhythmia

Endocrine/Metabolic
Diabetes Mellitus, non-insulin dependent
Diabetes Mellitus, insulin dependent
Diabetes Mellitus, uncontrolled
Goiter
Gout
Hyperthyrodism
Hypothyrodism
Impaired Glucose Tolerance

General
Allergies
Electrical Injury
Exposure to Chemicals
Hepatitis A
Hepatitis B
Hepatitis C
Hypercholestolemia
Hyperlipidemia
Infectious Disease
Lipid Disorder
Malaise
Obesity
Paget's Disease
PCKD
PCO
Raynaud's Syndrome

GI
Cholecystitis
Cholelethiasis
Chronic Liver Disease
Colitis
Constipation
Colon Condition
Crohn's Disease
Diarrhea
Diverticulitis
Diverticulosis
GERD
Hemorrhoids
Hepatic Failure
Hepatitis
Hiatal Hernia
Inflammatory Bowel Disease
Liver Disease
Pancreatitis
Peptic Ulcer (Duodenal)
Rectal Fissure
Stomach Ulcer
Ulcerative Colitis

GU
AIDS
Bladder Outlet Obstruction
Bladder Stone
Bladder Infection
Chronic Renal Disease
Chronic Renal Insufficiency
Chronic Renal Failure
Crossed Fused Ectopia
Hematuria
Impotence of Organic Origin
Interstitial Cystitis
Irradiation Therapy
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones
Libido Decreased
Nephrolithiasis
Nephrotic Syndrome
Neurogenic Bladder
Orchitis
Penile Discharge
Polycystic Disease
Polycystic Kidney Disease
Prostate Cancer
Radiation or Nuclear Exposure
Recurrent UTI
Renal Cell Cancer
Renal Failure
Renal Insufficiency
Testicular Cancer
Transplant Recipient
Bladder Cancer
Transitional Cell CA Ureter
Undescended Testicle (Birth)
Urinary Tract Infection
Venereal Disease

GYN/OB
Breast Cancer
Breast Disease
Endometriosis
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Fibroids

HEENT
Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Menniere's
Mumps
Sinusitis
Tinnitis
Vertigo

Musculoskeletal
Arthritis
Back Pain
Carpal Tunnel Syndrome
Claudication
Fibromyalgia
Mortons Neuroma

Neurological/Psychological
ADD
ADHD
Alcoholism
Alzheimer's Disease
Anxiety
Bi-polar Disorder
Chronic Fatigue Syndrome
Depression
Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Organic Brain Syndrome
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt

Respiratory
Asthma
Bronchitis
Chronic Lung Disease
COPD
Emphysema
Lung Disease
Pneumonia
Pulmonary Embolism
Sleep Apnea
Tuberculosis

Tumors
Brain Cell Carcinoma
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Fibrocystic Breast Disease
Gastric Cancer
Laryngeal Cancer
Lung Cancer
Lymphoma
Melanoma
Ovarian Cancer
Pancreatic Cancer
Rectal Cancer
Sarcoidosis
Testicular Cancer
Bladder Cancer
Transitional Cell CA Ureter
Uterine CA

Other: _____

SURGICAL HISTORY

Please CIRCLE if you have had any of the following surgeries and date of surgery:

Cadiovascular
Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery
Heart Surgery (Stents)
Heart Transplant
Pacemaker Insertion
Vein Stripping

General
Brain Surgery
Laminectomy
Lymphatic Node Dissection
Parathyroidectomy
Pilondial Cyst Incision
Skin Grafting

GI
Appendectomy
Bariatric Surgery
Bowel Resection
Cholecystectomy
Colon Resection
EGD
EGD/Dilation Esophagus
Fissurectomy
Gastric Surgery
Hemorrhoidectomy
Ileostomy
Laparoscopy
Liver Surgery
Liver Transplant
Lumpectomy of Breast
Lysis Adhesions
Nissen Fundoplication
Splenectomy
Stomach Surgery

GU
Bladder Surgery
Biopsy Prostate
Brachytherapy
Circumcision
Contigen
Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy-Stent
Cysto-TUR Fulguration
Durasphere
Epididymectomy
ESWL
Herniorrhaphy
Hydrocelectomy
Ileal conduit
Indigo Laser Surgery
Inguinal Herniorraphy
Interstim
Kidney Stone
Laser Lithotripsy
Meatotomy
Needle Biopsy Prostate
Nephrectomy
Nephrolithotomy
Orchiectomy
Orchiopexy
Penile Implant
Penectomy
Penile Surgery
Pyeloplasty
Radical Prostatectomy
Renal Transplant
Spermatocelectomy
TUMT Prostate
TUNA Prostate
TURBT
TUR Prostate
Ureteroscopy
Variocelectomy
Vasectomy
VLAP

GYN/OB
Hysterectomy

HEENT
Cataract Surgery
Corneal Surgery
Ear Surgery
Eye Surgery
Facial Surgery
Mastoid Surgery
Nasal Surgery
PEG
PE Tubes
Septoplasty
Sinus Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery

Musculoskeletal
Amputation
Arthroscopic Knee Surgery
Back Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Hip Surgery
Knee Surgery
Leg Surgery
Rotator Cuff Surgery
Shoulder Surgery

Respiratory
Lung Surgery

Skin
Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

Other: _____

_____

FAMILY HISTORY

Please CIRLCE and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle , Aunt)

Arthritis _____
Bedwetting _____
Bladder Cancer _____
Cancer (site unknown) _____
Crohn's Disease _____
Depression _____
Diabetes _____
Gout _____
Heart Attack _____
Hypertension _____
Kidney Cancer _____
Kidney Disease _____
Leukemia _____
Malignant Melanoma _____
Multiple Sclerosis _____
Laryngeal Cancer _____
Pancreatic Cancer _____
Prostate Cancer _____
Stroke _____
Thyroid Disease _____
Tuberculosis _____
Other: _____
Other: _____
Other: _____

Caffeinated beverages: None Low Moderate Excessive

Recent Foreign Travel: None Americas _____ Worldwide _____

Name: _____DOB_____Date: _____

PATIENT CURRENT-REVIEW OF SYSTEMS:

Constitutional
Appetite Changes
Anorexia
Aches and Pains
Chills
Easy Bruising
Fever
Fatigue
Generalized Weakness
Insomnia
Night Sweats
Sleep Apnea
Swollen Glands
Weight Gain
Weight Loss

Eyes
Blind
Blurred Vision
Double Vision
Glaucoma
Pain
Worsening Eyesight

Allergic/Immunologic
Animal Allergies
Drug Allergies
Environmental Allergies
Food Allergies
Seasonal Allergies

Neurological
Balance Problems
Disoriented
Dizzy Spells
Headache
Lack of Alertness
Leg or Arm Weakness
Memory Loss
Numbness/Tingling
Stroke
Speech Problems
Tremors

Endocrine
Diabetes
Excessive thirst
Pituitary Disease
Thyroid Disease
Tired/Sluggish
Too Hot/Cold

Gastrointestinal
Abdominal Cramps
Abdominal Pain
Acid Reflux
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Flatulence
Gas
Hemorrhoids
Indigestion/heartburn
Irregular Bowel Movements
Nausea/vomiting
Rectal Bleeding
Tarry Stool

Cardiovascular
Chest Pain/Angina
Dyspnea on Exertion
Edema
Heart Attack
Heart Failure
Heart Murmur
High Blood Pressure
Irregular Heart Beat
Mitral Valve Prolapse
Orthopnea
Pain/Cramps Hips/Legs w/exercise
Palpitation
Skipped Heart Beats
Swelling

Skin
Acne
Boils
Changing Moles
Persistent Itch
Pigment Change
Skin rash

Musculoskeletal
Arthritis
Back Pain
Gout
Joint Pain
Muscle Cramps
Muscle Weakness
Neck Pain/Stiffness

Ear/Nose/Throat
Ear Infection
Sinus Problem
Sore Throat

Genitourinary
Back Pain
Bedwetting
Blood in Urine
Dribbling
Burning on Urination
Erection Problems
Flank Pain
Hematuria
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Leak after voiding
Nocturia
Nocturnal Enuresis
Not Emptying
Painful Ejaculation
Stranguria
Stones
Suprapubic Pain
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Urinary Tract Infections
Urine retention
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream

Respiratory
Asthma
Emphysema-Bronchitis
Environmental Allergies
Frequent Cough
Pneumonia
Shortness of breath
Tuberculosis
Wheezing

Hematological/Lymphatic
Swollen Glands
Blood clotting problem
Bleeding Problem
Hepatitis
HIV (AIDS)
Sickle Cell

Psychologic
Anxiety
Depressed
Generally satisfied with life

Other:
_____
_____
_____
_____
_____

PATIENT SELF-ASSESSMENT:

BPH* SYMPTOM SCORE

Not at all	less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost the time	Always	Your score

Patient Name: DOB:

INCOMPLETE EMPTYING

Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating? 0 1 2 3 4 5 ☐

FREQUENCY

Over the past month, how often have you had to urinate again less than two hours after you finished urinating? 0 1 2 3 4 5 ☐

INTERMITTENCY

Over the past month, how often have you found you stopped and started again several times when you urinated? 0 1 2 3 4 5 ☐

URGENCY

Over the past month, how often have you found it difficult to postpone urination? 0 1 2 3 4 5 ☐

WEAK STREAM

Over the past month, how often have you had a weak stream? 0 1 2 3 4 5 ☐

STRAINING

Over the past month, how often have you had to push or strain to begin urination? 0 1 2 3 4 5 ☐

NOCTURIA

Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning? 0 1 2 3 4 5 ☐

BOTHERSOME OF URINARY SYMPTOMS

How would you feel if you had to live with your urinary condition the way it is now , no better, no worse, for the rest of your life?

DELIGHTED	PLEASED	MOSTLY SATISFIED	MIXED	MOSTLY DISSATISFIED	UNHAPPY	TERRIBLE
0	1	2	3	4	5	6