



First MI Last Suffix (Jr III, etc) Nickname

Street Address

City State Zip Code

Home Phone ( ) Work ( ) Cell ( )

Social Security Gender  Male  Female Birth Date

Retired  Disabled Your Employer

Email Address

Referring Doctor Clinic or Location

Primary Care Doctor Clinic or Location

<u>Marital Status</u> __ Single  __ Married __ Divorced __ Widow __ Separated	<u>Employment Status</u> __ Full time  __ Part time __ Not Employed __ Self Employed __ Retired	<u>Student</u> __ Full time  __ Part time __ Not a student	<u>Race/Ethnicity</u> __ American Indian/Alaska __ Asian __ Other PacificIslander __ Black or African American __ More than one Race __ Native Hawaiian __ White __ Not Reported	<u>Primary Provider</u> __ Brian S. Cope, MD  __ Scott C. Stoiff, MD  __ Jennifer Hanopole, PA-C
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Emergency Contact

Name

Relationship to you:  Spouse  Child  Parent  Other, specify

Address ( same as above)

City State Zip Code

Home Phone ( ) Work ( ) Cell ( )

Primary Insurance

Second Insurance (if any) Other (if any)

Who is the subscriber of the policy(ies)?  Self  Spouse  Father  Mother

If the subscriber is other than the patient, we need the following information to file your insurance:

Subscriber's Name Social Security Number Birth Date

Which local pharmacy do you use? Location

If you use a mail order pharmacy, please provide contact name/phone.

## Medical Information and Background

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Chief Complaint \_\_\_\_\_

### FEMALE PATIENT

- |   |  |
|---|--|
| <input type="checkbox"/> Blood in urine           | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Change in bladder habits | <input type="checkbox"/> Painful urination   |
| <input type="checkbox"/> Change in urine stream   | <input type="checkbox"/> Pelvic Pain         |
| <input type="checkbox"/> Flank (side) pain        | <input type="checkbox"/> Urinary urgency     |
| <input type="checkbox"/> Frequent urination       | <input type="checkbox"/> Urinating at night  |
| <input type="checkbox"/> Urinary incontinence     | <input type="checkbox"/> Vaginal bleeding    |
| <input type="checkbox"/> Menstrual irregularities | <input type="checkbox"/> Vaginal discharge   |

### MALE PATIENT

- |   |   |
|---|---|
| <input type="checkbox"/> Blood in urine       | <input type="checkbox"/> Painful urination  |
| <input type="checkbox"/> Discharge            | <input type="checkbox"/> Penile curvature   |
| <input type="checkbox"/> Flank (side) pain    | <input type="checkbox"/> Penile lesions     |
| <input type="checkbox"/> Frequent urination   | <input type="checkbox"/> Testicular mass    |
| <input type="checkbox"/> Hesitancy            | <input type="checkbox"/> Testicular pain    |
| <input type="checkbox"/> Impotence            | <input type="checkbox"/> Urinary urgency    |
| <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Urinating at night |

**YOUR ALLERGY HISTORY:** Are you allergic to any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Penicillin What was your reaction? | <input type="checkbox"/> IV contrast What was your reaction?     |
| <input type="checkbox"/> Cipro What was your reaction?      | <input type="checkbox"/> Iodine/Betadine What was your reaction? |
| <input type="checkbox"/> Sulfa What was your reaction?      | <input type="checkbox"/> Latex What was your reaction?           |

Please list any other medication allergies or food allergies:

_____	_____
What was your reaction?	
_____	_____
What was your reaction?	
_____	_____
What was your reaction?	
_____	_____
What was your reaction?	
_____	_____
What was your reaction?	

**FAMILY MEDICAL HISTORY** Please indicate family member (example: your mother, father, brother/sister, paternal or maternal grandfather, maternal aunt/uncle, etc.)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Alcohol Abuse         | <input type="checkbox"/> Cerebrovascular Disease (stroke)     | <input type="checkbox"/> Parkinson's Disease                     |
| <b>CANCER</b>                                  | <input type="checkbox"/> Ulcerative Colitis                   | <input type="checkbox"/> Osteoporosis                            |
| <input type="checkbox"/> Breast Cancer         | <input type="checkbox"/> Coagulopathy (blood clotting defect) | <input type="checkbox"/> Sickle Cell Anemia                      |
| <input type="checkbox"/> Cervical Cancer       | <input type="checkbox"/> Coronary Artery Disease (narrowing)  | <input type="checkbox"/> Sickle Cell Disease                     |
| <input type="checkbox"/> Colon Cancer          | <input type="checkbox"/> MI (heart attack)                    | <input type="checkbox"/> Chronic Cystitis (bladder inflammation) |
| <input type="checkbox"/> Lung Cancer           | <input type="checkbox"/> Crohn's Disease                      | <input type="checkbox"/> Seizures                                |
| <input type="checkbox"/> Ovarian Cancer        | <input type="checkbox"/> Deafness                             | <input type="checkbox"/> Urinary Incontinence                    |
| <input type="checkbox"/> Prostate Cancer       | <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Kidney Stones (Nephrolithiasis)         |
| <input type="checkbox"/> Renal (kidney) Cancer | <input type="checkbox"/> Fibrocystic Breast Disease           | <input type="checkbox"/> BPH (enlarged prostate)                 |
| <input type="checkbox"/> Skin Cancer           | <input type="checkbox"/> High cholesterol                     | <input type="checkbox"/> Hyperlipidemia                          |
| <input type="checkbox"/> Thyroid Cancer        | <input type="checkbox"/> Hypertension (high blood pressure)   | <input type="checkbox"/> Other, please list below:               |
|  | <input type="checkbox"/> Depression                           |  |

YOUR PAST MEDICAL HISTORY

- Anemia
- Arthritis
- Bladder Neck Contracture
- BPH
- CANCER
  - Bladder Cancer
  - Brain Cancer
  - Breast Cancer
  - Cervical Cancer
  - Colon Cancer
  - Lung Cancer
  - Ovarian Cancer
  - Prostate Cancer
  - Rectal Cancer
  - Renal (kidney) Cancer
  - Skin Cancer
  - Stomach Cancer
  - Thyroid Cancer
- Chronic Bronchitis
- Chronic Prostatitis
- Colonic Polyps
- Duodenal Ulcer
- Congenital Malformation
- Congestive Heart Failure
- COPD
- Coronary Artery Disease
- CVA (stroke)
- Degenerative Disc Disease
- Degenerative Joint Disease
- Dementia
- Depression
- Diabetes
- Drug Dependence
- Elevated PSA
- Epididymitis
- Erectile Dysfunction
- Gastric Ulcer
- Gastroesophageal Reflux Disease
- Gestational Diabetes Mellitus (during pregnancy)
- Glaucoma
- Gout
- Hiatal Hernia
- Human Immunodeficiency Virus Infection (HIV)
- Hyperlipidemia
- Hypertension (high blood pressure)
- Hypothyroidism
- Inguinal Hernia
- Irritable Bowel Syndrome
- Mononucleosis
- Kidney Stones (Nephrolithiasis)
- Peyronie's Disease (curvature of penis)
- Pneumonia
- Psychological Stress
- Psychological Trauma
- Seizure Disorder
- Sexually Transmitted Disease
- Thrombophlebitis
- TIA (mini strokes)
- Tuberculosis
- Urethral Stricture
- Urinary Tract Infection

YOUR SURGICAL HISTORY

- Aneurysm Repair
- Appendectomy
- Breast Biopsy
- Cardiac Stent Placement (# of vessels \_\_\_\_\_)
- Cataract Removal
- Cesarean Section (# \_\_\_\_\_)
- Cholecystectomy (removal of gall bladder)
- Coronary Artery Bypass (# of grafts \_\_\_\_\_)
- Cystoscopy, Stent Placement
- Detached Retina
- ESWL (Lithotripsy)
- Hysterectomy
- Inguinal Hernia Repair
- TURP (with laser)
- Laminectomy
- Lumpectomy
- Mastectomy
- Oophorectomy
- Prostate Biopsy
- Prostate Cryotherapy
- Prostatectomy (Radical / Suprapubic)
- Resection of Large Bowel
- Resection of Stomach
- Salpingectomy (Removal of fallopian tubes)
- Splenectomy (Removal of spleen)
- Thyroidectomy (Subtotal / Total)
- Tonsillectomy
- TURBT
- TURP
- Umbilical Hernia Repair
- Ureteroscopy
- Vasectomy
- Ventral Hernia Repair
- Other, please specify

DIAGNOSTIC PROCEDURES

- Bone Density Study
- Bone Scan
- Breathing Capacity Test
- Cardiovascular Stress Test
- Colonoscopy
- CT Scan
- Echo Exam of Heart with ECG monitor
- Electrocardiogram
- Mammogram
- Sigmoidoscopy

CURRENT WORK STATUS

- Disabled
- Full-time
- Part-time
- Retired
- Self-Employed
- Unemployed looking for work
- Unemployed not looking for work

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TOBACCO/SMOKER

Cigarettes       Snuff       Cigar/Pipe

Packs/day \_\_\_\_\_

DRUG USE

- Never used drugs
- Occasional drugs use
- Heavy drug use
- What year did you quit using drugs \_\_\_\_\_

- Never smoked
- Occasional smoker
- Heavy smoker
- What year did you quit tobacco products \_\_\_\_\_

ALCOHOL

- Never used alcohol
- Occasional (social) alcohol
- Heavy alcohol use
- What year did you quit using alcohol \_\_\_\_\_

CAFFEINE USE(coffee, tea, sodas)

- Never drink caffeine products
- Occasional drink caffeine products
- Moderate drink caffeine products
- Heavy drink caffeine products

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PLEASE LIST YOUR CURRENT MEDICATIONS

Medication Name

Dosage

Times/Day

- Do you take an aspirin daily?       Yes       No
- Do you take vitamins daily?       Yes       No
- Do you take herbal supplements?       Yes       No
- Do you take birth control pills?       Yes       No

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Are there 3 questions you would like to discuss with your doctor today?

1

2

3

Entered by: \_\_\_\_\_



1236 Huffman Mill Road, Suite 2550  
Burlington, NC 27215  
Phone: (336) 584-6300

**CONSENT FOR TREATMENT**

I authorize the physicians and other medical providers of Imprimis Urology, PC and all assistants to administer treatment as deemed necessary with no guarantee or assurance as to the results of such treatment.

**INSURANCE BENEFITS**

I authorize payment to Imprimis Urology, PC otherwise payable to me including major medical insurance not to exceed regular charges for these services. I understand that I am financially responsible to Imprimis Urology, PC for all charges not covered by this arrangement.

I authorize the release of information to and the request of payment to Imprimis Urology, PC. I certify that the information given by me in applying for benefits is correct. I will provide new and up-to-date insurance information to Imprimis Urology, PC when there is a change or discontinuance of insurance coverage. I authorize the release of all such information as required by my insurance carrier to act on this request, and the payment of benefit to be made on my behalf.

**RELEASE OF MEDICAL INFORMATION**

Imprimis Urology, PC is authorized to release any medical information necessary in the processing of applications for financial coverage for service(s) provided. Imprimis Urology, PC is further authorized to provide information to other health or legal agencies involved in my care as provided for by current HIPPA regulations.

**FINANCIAL ARRANGEMENTS**

At Imprimis Urology, PC, our goal is to provide the best possible care and service available anywhere and every effort will be made to achieve this goal in a cost effective manner, provided that this may be done without compromise to the care delivered. We will file your primary insurance as an additional service.

- ◆ Payment is due at the time of service. (We accept cash, check, VISA, MasterCard, Discover Card, and American Express)
- ◆ Return checks will be subject to a \$25.00 fee.
- ◆ Balances over 30 days may be subject to additional collection fees and interest charges.
- ◆ A fee will be charged if appointments are missed without 24 hour prior notice of cancellation.

Please note that Imprimis Urology, PC has a relationship with and responsibility to you and not your insurance carrier, unless otherwise stated by direct contract with your insurance carrier. We will work to assist you in the acquisition of payment from your carrier and will ask that you do the same to assist obtaining payments from the insurance carrier. If you have not been notified of payment within 30 days of service, please call your insurance carrier and help us secure prompt payment. If a personal situation arises so that payment is not made in full within 45 days, please contact our Insurance and Billing Manager such that arrangements can be made that might assist you. We cannot allow idle accounts to simply be ignored.

I hereby certify that I have read and understand the information above. If I do not understand this information, it has been explained to me.

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Signature

Printed Name

Date



1236 Huffman Mill Road, Suite 2550  
Burlington, NC 27215  
Phone: (336) 584-6300

## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Imprimis Urology, PC to use and disclose protected information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Imprimis Urology, PC Notice of Privacy Practice provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Imprimis Urology, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Imprimis Urology, PC Privacy Officer at 1236 Huffman Mill Road, Suite 2550, Burlington, NC 27215.

With this consent, Imprimis Urology, PC may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, referral information, and any calls pertaining to my clinical care, including laboratory, radiology and any other results.

With this consent, Imprimis Urology, PC may mail to my home or other alternative location any items that assist the practice carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent Imprimis Urology, PC may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder information, patient statement. I have the right to request that Imprimis Urology, PC restrict how it uses or discloses my PHI to carry out TPO.

However Imprimis Urology, PC is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Imprimis Urology, PC use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Imprimis Urology, PC may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

Date

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Printed Name of Patient or Legal Guardian

If not patient, relation or POA information