



Dear New Patient:

Welcome to Morristown Urology Group, a division of Garden State Urology. The physicians in our group are board-certified, fellowship trained urologists who provide state-of-the-art care that rivals the finest academic institutions in our country. Our staff is dedicated to making your visit as comfortable as possible and achieving the highest level of care. Please assist us in our goals by carefully reading the following instructions and completing all forms in their entirety.

To make your first visit as smooth as possible, we ask that the following forms be completed and sent to us via email or fax **AT least 1 day** PRIOR to your appointment:

- Patient History Form** –We recommend that you have your medication bottles handy when completing this form so the information is accurate.
- Registration Form** completed with signed Financial Agreement
- Provide a copy of your **insurance card** – front AND back (make sure ID #s are legible)

We have established a private/secure email and fax number for you to use:

EMAIL - registrations@gsunj.com

FAX - 973-947-9051

Do **NOT** mail the forms! If you are unable to email or fax the forms, simply bring them with you to your appointment.

Please remember to arrive 15 minutes prior to your scheduled appointment with the following documents or your appointment may be delayed until the proper documents are obtained:

- Bring the completed forms with you** in case there is a problem with the processing of your forms. **We do not want you to have to complete the forms again.**
- Registration and History forms
- Photo ID (driver's license, passport or visa)
- Referral, if it is required by your insurance.** Please make sure that you bring that document with you to your appointment. If you do not bring this information you will be held responsible for the charges occurred on that day
- The consult/referral form included in this packet is necessary regardless of your insurance requirements. If the referring physician did NOT give you a referral document, please ask them to complete the enclosed CONSULT REFERRAL FORM prior to your scheduled appointment. If your physician did give you a consult referral or prescription stating the reason for the visit then you do not have complete the attached form. Please have it faxed or emailed to our office, or bring it with you the day of the visit.** If you are self-referred patient and no other physician is involved in your medical care this documentation is not necessary.
- Insurance card(s)
- Lab results, especially blood work and urine cultures any other tests or medical results that pertain to your visit.
- Radiology testing (reports and films/CD) *It is your responsibility to bring these items to your appointment. You cannot rely on the facility to deliver them.

If you need to reschedule your appointment or have any questions please call our office at (973) 539-1050 so that we may give that time to another person in need and arrange a more convenient time for you.

Sincerely,
The Scheduling Staff

Morristown Urology

ADULT REGISTRATION FORM: Please complete the entire registration form.

Physician you are here to see: _____

Patient's Name: _____ **Home Phone#:** _____
Last First Middle

Cell Phone #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ **Work Phone #:** _____

Email address _____

Patient Social Security#: _____ Patient's Sex: Male Female

Patient Date of Birth: _____ Patient Marital Status: M S D W

Employer: _____ Occupation: _____ Address: _____

Spouse's Full Name: _____ Contact #: _____

Emergency Contact: _____ Contact #: _____ Relationship: _____

Primary Care Doctor: _____ Phone: _____ Address: _____

Doctor who referred you (if different from primary): _____ Phone: _____ Address: _____

Pharmacy Name: _____ Town: _____ Phone#: _____

INSURANCE INFORMATION (Must be completed in full so that we may submit to your insurance for reimbursement.)

Primary Insurance: _____

Policyholder's name (insured's name): _____ Date of Birth: _____

Sex: Male Female Social Security #: _____ Employer: _____

Patient's relationship to insured (please circle): Self Spouse Child Other/Dependent

Group Number: _____ Policy Number: _____

Secondary Insurance: _____

Policyholder's name (insured's name): _____ Date of Birth: _____

Sex: Male Female Social Security #: _____ Employer: _____

Patient's relationship to insured (please circle): Self Spouse Child Other/Dependent

Group Number: _____ Policy Number: _____

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Garden State Urology for any service furnished to me by GSU's physicians. I authorize Garden State Urology to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due the physician. These amounts could include annual deductibles, co-payments, charges denied as not covered by Medicare or my insurance program, and charges denied for services determined as not medically necessary. I further understand that if GSU incurs any fees associated with collecting reimbursement on my account, I will be responsible for paying those fees.

Signature: _____ **Date:** _____

Date: _____

ADULT HISTORY FORM

Patient Name: _____ DOB: _____

Primary Care Physician Name: _____ Phone: _____

Other Treating Physician Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Reason for today's visit (New Patients ONLY) _____

Allergies: Please list any drug allergies (including latex and shellfish, if applicable.) Please circle NONE if you do not have any known allergies.

_____ **NONE**

Medications: Please list all the medications you are currently taking (including OTC medications such as aspirin), dosage and frequency. For example: *Aspirin 325mg daily.*

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

****If you are unable to fit all medications on the above list, please attach an additional page****

Past Surgical History: Please list all surgeries. Include approximate dates, if possible.

Procedure: _____ Date: _____ Procedure: _____ Date: _____

Procedure: _____ Date: _____ Procedure: _____ Date: _____

****If you are unable to fit all your procedures/surgeries in the above space, please utilize the back of the page****

Past Medical History: Do you have or have you had any of the following medical conditions?

Diabetes	Type 1	Type 2	NO	Heart Disease	YES	NO	Arthritis	YES	NO	
Asthma		YES	NO	Thyroid Disease	Hyper	Hypo	NO	Indigestion	YES	NO
High Blood Pressure		YES	NO	Cancer		YES	NO	Other:	_____	
Kidney Stones		YES	NO	If YES please specify:				_____		

Race (Optional): (Requested by the state of New Jersey for Cancer Registry)

Caucasian
 African American
 American Indian
 Asian Indian/Pakistani
 Hispanic
 Asian
 Other _____

Height: _____

Weight: _____

Family History: Do you have a *family* history of any of the following?

Prostate Cancer YES NO Bladder Cancer YES NO Kidney Cancer YES NO

Please list all serious illnesses in your *family* and indicate the relationship to you:

Social History:

Occupation: _____ Marital Status: _____ # of Children: _____

Do you currently smoke? YES NO Did you ever smoke? YES NO

How many packs per day? _____ When did you quit? _____

Do you drink alcohol? YES NO How many drinks per week? _____

Review of Systems: Do you now or have you had any problems related to the follow systems. **Please circle any that apply. If none apply, please circle None.**

Constitutional :	None	Fever	Chills	Other: _____	
Neurological :	None	Tremors	Dizzy spells	Other: _____	
Hematologic/ Lymphatic :	None	Clotting problems	Swollen glands	Blood transfusion	Other: _____
Musculoskeletal :	None	Joint pain	Neck pain	Other: _____	
Gastrointestinal :	None	Abdominal pain	Nausea/ Vomiting	Other: _____	
Psychological :	None	Depression	Psychosis	Other: _____	
Cardiovascular :	None	Chest pain	Heart attack	Heart murmur	Other: _____
Endocrine :	None	Excessive thirst	Tired/ Sluggish	Diabetes mellitus	Other: _____
Respiratory :	None	Emphysema	Shortness of breath	Other: _____	
Integumentary/ Skin :	None	Skin rash	Persistent itch	Other: _____	
Genitourinary :	None	Urinary tract infection	Blood in urine	Kidney stone	Other: _____

Physician Reviewed/Date: _____ Physician Reviewed/Date: _____ Physician Reviewed/Date: _____

Patient Comments: Please comment on any issues/problems not covered in the above questions.

Patient Signature: _____ **Date:** _____

Atlantic Medical Group

Consult Request Form

Today's consultation with Dr. _____ is a
request for consultation for _____
(Patient name/DOB)
DX. _____.

YES NO Requesting advice/opinion with treatment and continued co-management.

YES NO Requesting advice/opinion.

973-538-6111

Please complete this form and fax it to: _____

A copy of this request should be filed in the medical record of both the originating physician and the consulting physician.

Referring Physician Signature

Date



Acknowledgement of Receipt

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians and staff.

Print Name of Patient or Patient’s Personal Representative

Signature of Patient or Patient’s Personal Representative

Description of Personal Representative’s Authority

Date

Consent to Discuss Health Care

Patient Name: _____

Today’s Date: _____

Date of Birth: _____

I authorize _____ to discuss my health care information with the individuals listed below.

Name: _____ Telephone #: _____ Relationship: _____

Name: _____ Telephone #: _____ Relationship: _____

Name: _____ Telephone #: _____ Relationship: _____

I give permission to leave my health care information at the following telephone number(s).

Home: _____

Cellular: _____

Work: _____

Other: _____

I consent for Garden State Urology to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology as a reminder of a previously booked appointment date and time. _____ (initial)

Opt out from receiving text messages: _____ (initial)

Signature of Patient, Parent or Legal Guardian

Printed Name