GARDEN STATE UROLOGY

Merging compassion & innovation.

Dear New Patient,

Welcome to Associates in Urology North Jersey, a Division of Garden State Urology. Our physicians are dedicated to providing state of the art urologic care in a friendly, caring environment. 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
- Provide a copy of your **insurance card-** front AND back (make sure ID# is 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 back! 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 license's, 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 incurred 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. Please have it faxed to our office, or bring it with you the day of your visit. If your physician did give you a consult referral or prescription stating the reason for the visit, then you do not have to complete the attached form. If you are a 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, or any other tests or medical results that pertain to your visit
- Radiology tests (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 please call our office at 973-616-8400 so that we may give that time to another person in need and arrange a more convenience time for you.

Sincerely,
The Scheduling Staff

ADULT REGISTRATION FORM: Please complete the entire registration form.

Physician you are here to see: _____

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

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: _____ Cell/Work #: _____

Emergency Contact: _____ Home/Cell #: _____ 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

Policy Number: _____ Group 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

Policy Number: _____ Group 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:** _____

Atlantic Medical Group

Consult Request Form

Today's consultation with Dr. _____ is a

request for consultation for _____
(Patient name)

DX. _____.

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

YES NO Requesting advice/opinion.

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

For office use only

- S.R.

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 HealthCare

Patient Name:_____

Today's Date_____ Date of Birth_____

I authorize_____
to discuss my healthcare information with the individuals listed below.

Name:_____Telephone#_____Relationship:_____

Name:_____Telephone#_____Relationship:_____

Name:_____Telephone#_____Relationship:_____

I give permission to leave my healthcare 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

ASSOCIATES IN UROLOGY NORTH JERSEY, PA

NAME_____ **SS#**_____ **DATE**_____

REASON FOR VISIT_____

_____

_____

_____

MEDICAL CONDITIONS DIABETES_____HIGH BLOOD PRESSURE_____(PLEASE LIST ALL OTHERS)

_____

_____

_____

HOSPITALIZATIONS YES__NO__ IF YES WHEN, WHERE AND FOR WHAT CONDITION

_____

_____

_____

SURGICAL PROCEDURES (PLEASE LIST) WHEN PHYSICIAN WHERE TREATED

_____

_____

_____

MEDICATIONS (INCLUDE **OVER THE COUNTER**):_____

_____

_____

_____

ALLERGIES_____

_____

SMOKE___ HOW MUCH_____QUIT WHEN_____ ALCOHOL_____ HOW MUCH_____QUIT WHEN_____

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING:

CANCER_____DIABETES_____HEART DISEASE_____ HIGH BLOOD PRESSURE_____KIDNEY DISEASE_____

INDICATE THE HEALTH STATUS OF FAMILY, IF DECEASED GIVE AGE AND CAUSE OF THE DEATH:

MOTHER_____

FATHER_____

BROTHERS_____

SISTERS_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

REVIEW OF SYSTEMS
Do you now or have you had any problems related to the following?
PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES or NO

Constitutional Symptoms
- Weight change Y N
- Loss of Appetite Y N
- Other_____

Eyes
- Blurred vision Y N
- Double vision Y N
- Difficulty seeing Y N
- Glaucoma Y N
- Other_____

Ear/Nose/Throat
- Ear infection Y N
- Sore throat Y N
- Difficulty hearing Y N
- Wear a hearing aid Y N
- Other_____

Cardiovascular
- Palpitations Y N
- Chest pain Y N
- Abnormal cholesterol Y N
- High blood pressure Y N
- History of heart attack Y N
- Other_____

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Emphysema Y N
- Other_____

Gastrointestinal
- Abdominal pain Y N
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Change in bowel habits Y N
- History of colon cancer Y N
- Other_____

Gynecologic
- Abnormal vaginal bleeding Y N
- Abnormal discharge Y N
- Irregular periods Y N
- Menopause Y N
- History of breast cancer Y N
- Last menstrual period_____
- Other_____

Musculoskeletal
- Joint pain Y N
- Neck pain Y N
- Back pain Y N
- Arthritis Y N
- Other_____

Integumentary
- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other_____

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Thyroid problem Y N
- Other_____

Hematologic/Lymphatic
- Swollen glands Y N
- Blood clotting problems Y N
- Other_____

Neurologic
- Stroke TIA Y N
- Tremors Y N
- Dizzy spells Y N
- Numbness or tingling Y N
- Frequent headaches Y N
- Other_____

Allergic/Immunologic
- Hay fever Y N
- Drug allergies Y N
- Allergic to shellfish Y N
- Take antibiotics prior to dental procedures Y N
- Other_____

Other_____

#Answers	Level of Service
0-1	1 or 2
2-9	3
10+	4 or 5