Dear New Patient:

Welcome to Associates in Pediatric and Adult Urology, PA, a division of Garden State Urology.

Attached you will find the patient registration form, health history form, acknowledgement of receipt of privacy practices, financial agreement and directions. 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:

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

EMAIL - registrations@gsunj.com
FAX - 973-947-9051

1- Completed New Patient Packet

2- Bring Photo ID (License, Passport, and VISA)

3- Insurance cards

4- Referral, if required by your insurance.

5- Lab results, especially blood work and urine cultures

6- Radiology testing (Reports and Films/CD) * It is your responsibility to hand deliver these items at your appointment. Do not rely on the facility to deliver them.

7- A current list of medications you are taking.

8- Any other tests or medical results that pertain to your visit.

Please arrive 30 minutes prior to your first appointment with the requested documentation. Our goal is to help you attain your highest level of care by our staff and physicians.

If you have any questions, please call our office at 973-627-4055.

Sincerely,

The Scheduling Staff

**IF YOU ARE SCHEDULED FOR AN APPOINTMENT IN THE DENVILLE OFFICE DO NOT USE A GPS TO LOCATE THE OFFICE IT WILL TAKE YOU TO THE WRONG LOCATION. The Denville office is located at 282 Route 46 West and the corner of Birchwood Road.
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: ____________________________ Work Phone #: __________________

City: ________________ State: _______ Zip Code: __________

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: _______________
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.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
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</thead>
<tbody>
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</tbody>
</table>

***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?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Type</th>
<th>Type</th>
<th>Type</th>
<th>Type</th>
<th>Type</th>
<th>Type</th>
<th>Type</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Type 1</td>
<td>Type 2</td>
<td>Type 3</td>
<td>Type 4</td>
<td>Type 5</td>
<td>Type 6</td>
<td>Type 7</td>
<td>Type 8</td>
</tr>
<tr>
<td>Asthma</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Kidney Stones</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td>Hyper</td>
<td>Hypo</td>
<td>Hyper</td>
<td>Hypo</td>
<td>Hyper</td>
<td>Hypo</td>
<td>Hyper</td>
<td>Hypo</td>
</tr>
<tr>
<td>Cancer</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

If YES please specify:

| Other:___________________|
|________________________|

Revised 02/2013
Race (Optional): (Requested by the state of New Jersey for the Cancer Registry)

___Caucasian                ___African American                ___American Indian          ___Asian Indian/Pakistani
___Hispanic                   ___Asian                                      ___Other__________________________________

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.

<table>
<thead>
<tr>
<th>System</th>
<th>Yes</th>
<th>No</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematologic/Lymphatic</td>
<td>None</td>
<td></td>
<td></td>
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<tr>
<td>Musculoskeletal</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>None</td>
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<tr>
<td>Psychological</td>
<td>None</td>
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<tr>
<td>Cardiovascular</td>
<td>None</td>
<td></td>
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<tr>
<td>Endocrine</td>
<td>None</td>
<td></td>
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<tr>
<td>Respiratory</td>
<td>None</td>
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<td></td>
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<tr>
<td>Integumentary/Skin</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears, Nose, Mouth, Throat</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:________________
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