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:** _____

GARDEN STATE UROLOGY
Merging compassion & innovation.

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:_____

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****

Height:_____ **Weight:**_____

Past Medical History:

Have you had the Pneumonia vaccine? YES NO When?_____

Have you had a Colonoscopy? YES NO When?_____

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_____

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? _____

Signature: _____ **Date:** _____

International Prostate Symptom Score (I-PSS)

Patient Name:_____ Date of birth:_____ Today's Date:_____

Please answer the following questions based on your experience during the **past month**. Circle your answers.

In the past month:	NOT AT ALL	LESS THAN 1 IN 5 TIMES	LESS THEN HALF THE TIME	ABOUT HALF THE TIME	MORE THAN HALF THE TIME	ALMOST ALWAYS
Incomplete Emptying How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency How often have you had to urinate again less than 2 hours after you've finished urinating?	0	1	2	3	4	5
I**ntermittency** How often have you found you stopped and started several times when you urinated?	0	1	2	3	4	5
Urgency How often do you find it difficult to postpone urination?	0	1	2	3	4	5
Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining How often have you had to push or strain to begin urination?	0	1	2	3	4	5
	NONE	**1 TIME**	**2 TIMES**	**3 TIMES**	**4 TIMES**	**5 TIMES**
Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5

Total_____

MILD (0-7) Moderate (8-19) Severe (20-35)

How would you feel if you were to spend the rest of your life with your urinary condition just the way it is now?

DELIGHTED	PLEASED	MOSTLY SATISFIED	MIXED	MOSTLY UNSATISFIED	UNHAPPY	TERRIBLE

PATIENT/FAMILY CONTACT LIST

PATIENT'S Name: _____ DOB: _____

Contacts

People who have permission to receive detailed information about your care (PHI):

PRIMARY CONTACT	
Name: Relationship: ☐ Self or Other: _____	Phone Numbers Cell: _____ _____ _____ Home: _____ _____ _____ Other: _____ _____ _____
☐ Check here if you would like us to involve this person in discussions about your health care	Ok to leave a message: Yes ☐ No ☐
SECONDARY CONTACT (S)	
Name: Relationship: _____	Phone Numbers Cell: _____ _____ _____ Home: _____ _____ _____ Other: _____ _____ _____
☐ Check here if you would like us to involve this person in discussions about your health care	Ok to leave a message: Yes ☐ No ☐
Name: Relationship: _____	Phone Numbers Cell: _____ _____ _____ Home: _____ _____ _____ Other: _____ _____ _____
☐ Check here if you would like us to involve this person in discussions about your health care	Ok to leave a message: Yes ☐ No ☐

☐ **I decline to designate a representative at this time.**

Comments/Other information:

_____

_____

_____

_____

This form is effective upon execution and will remain in effect unless revoked by me.

Patient/Guardian Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____