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:** _________________

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** If YES please specify:	YES	NO	**Other:**_______________ ______________________		
Kidney Stones		YES	NO						

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:** _________________

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: _______________________________________