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.
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:

- **Patient History Form** –We recommend that you have your medication bottles handy when completing this form so the information is accurate.
- **Registration Form**
- 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.
The reason we are requesting that you complete the forms and send them to us PRIOR to your appointment is because we are implementing an Electronic Medical Record (EMR). The EMR enables a patient's information to be immediately accessible to physicians for a more efficient delivery of medical care. An EMR will also enable us to perform electronic prescribing which will speed up medication orders/refills. In order for the physicians and staff to utilize the EMR properly, we need to have the registration and history form information entered PRIOR to your appointment. If you are unable to fax or email your paperwork prior to your appointment, then the staff will have to enter it upon your arrival and this may delay your appointment.
Please remember to arrive 15 minutes prior to your scheduled appointment with the following 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.**
- Pediatric Registration forms
    a. Registration form
    b. Medical history forms
    c. Wetting questionnaire (if applicable to your visit)
    d. Voiding diary (if applicable to your visit)
- Guardian's Photo ID (driver's license, passport or visa)
- Insurance card(s)
- Electronic insurance referral (generated by your referring/ primary care physician), if it is required by your medical insurance, or if you are referred by another physician (hand written on a prescription pad is acceptable). If the **required electronic insurance** referral is not received at our office by the time of your scheduled appointment, you will have to either pay in full or reschedule the appointment.
- Lab results, especially blood work and urine cultures
- Radiology testing, especially VCUG or ultrasounds (reports and films/CD) *It is your responsibility to bring these items to your appointment. You can not rely on the facility to deliver them.
- Any other tests or medical results that pertain to your visit.

If you need to reschedule your appointment 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

PEDIATRIC REGISTRATION FORM

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

Street Address: _____City: _____State:_____ Zip: _____

Patient's Date of Birth_____ Patient's Sex: Male Female

Patient's Social Security#: _____

Parent Information:

Mother's Name:_____ Father's Name: _____
Home Address:_____ Home Address: _____
Mother's Birth Date:_____ Father's birth date: _____
Employer's Name: _____ Employer's Name: _____
Employer's Address:_____ Employer's Address:_____
Work Number:_____ Work Number: _____
Cell Number: _____ Cell Number: _____
Email Address:_____ Email Address: _____

If parents are divorced or separated is there a court order or other financial arrangement we need to be aware of?

_____Name of Step Parent_____

Emergency Contact: _____Home/Cell#: _____Relationship: _____

Pediatrician Name: _____

Address: _____ City_____ State_____ Phone # _____

Referring Doctor (if different from Pediatrician) _____

Address: _____ City_____ State_____ Phone #:_____

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 Information:

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

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

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

Policy #: _____ Group #: _____

Secondary Insurance: _____

Policyholder's Information:

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

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

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

Policy #: _____ Group #: _____

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Garden State Urology, LLC, for any service furnished to me by GSU's physicians. I authorize Garden State Urology, LLC 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.

Signature: _____ Date:

_____

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TODAYS DATE_____

PEDIATRIC HISTORY FORM

Patient Name: _____ DOB: _____

Primary Care Physician Name: _____ Phone: _____

Other Treating Physician Name: _____ Phone: _____
Pharmacy Name: _____ Phone: _____

Pharmacy Address:_____City:_____State:_____Zip:_____

Medical reason for today's visit (New Patients ONLY): _____

Allergies: Please list any allergies your child may have to any medications .Please circle NONE if they do not have any known allergies.

_____ **NONE**

Medications: Please list all the medications your child is currently taking, dosage and frequency. For example: *Aspirin 325mg daily.*

Medication	**Dosage**	**Frequency**

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: Does your child have or had any of the following medical conditions?

Diabetes	Type 1	Type 2	NO	**Kidney Disease**		YES	NO	**Heart Disease**		YES	NO
Asthma		YES	NO	**Thyroid Disease**	Hyper	Hypo	NO	**Other**		Yes	NO
High Blood Pressure		YES	NO	**Cancer**		YES	NO	If yes, please explain:			
Kidney Stones		YES	NO	If YES please specify:							

When you were pregnant with this child: What was the length of pregnancy? _____

Was the pregnancy ? **NORMAL** **ABNORMAL** If abnormal, describe_____

IN-Vitro **YES NO**

If you had a pregnancy ultrasound, was it **NORMAL** **ABNORMAL**

Family History: Do you have a *family* history of any of the following?(grandparents, parents or siblings)

Diabetes	Type 1	Type 2	NO	**Kidney Disease**	YES	NO	**Heart Disease**	YES NO
Recurrent UTI's	YES	NO		**Hernias**	Yes	NO	**Bedwetting**	YES NO
High Blood Pressure	YES	NO		**Cancer** If YES please specify:	YES	NO	**Other**	YES NO
Kidney Stones	YES.	NO					If yes, please explain:	
Bladder Anomolies	YES	NO						
Genital Problem	YES	NO		**Undescended Testis**	YES	NO		

Social History: Who does the child live with?_____

Does anyone in the home smoke? Yes No What grade is the patient in?_____

Review of Systems: Is your child experiencing any of the following problems? **Please circle any that apply. If none apply, please circle NONE.**

Constitutional :	None	Fever	Chills	Headache	Other_____	
Neurological :	None	Tremors	Numbness Tingling	Weakness	Other_____	
Allergic/ Immunologic :	None	Seasonal Allergies	Drug Allergies	Other:_____		
Musculoskeletal :	None	Joint pain	Other:_____			
Gastrointestinal :	None	Abdominal pain	Nausea/ Vomiting	Other:_____		
Cardiovascular :	None	Heart Murmur	Other:_____			
Endocrine :	None	Excessive thirst	Other:_____			
Respiratory :	None	Wheezing	Shortness of breath	Frequent Cough	Other:_____	
Hematologic/ lymphatic :	None	Swollen Glands	Blood Disorder	Other:_____		
Genitourinary :	None	Painful Urination	Urinary Frequency	Urinary Tract Infection	Blood in Urine	**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:_____

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

David C. Saypol, M.D., M.S., F.A.C.S.
Arthur R. Israel, M.D., F.A.C.S.
David C. Chaikin, M.D., F.A.C.S.
Perry M. Sutaria, M.D., F.A.C.S.
Michele R. Clement, M.D., F.A.C.S.*
Lee B. Pressler, M.D., F.A.C.S.*
Barbara Hearle, NP-C*

MORRISTOWN UROLOGY

Dear New Patient and Family,

Welcome to my practice. Your initial visit will require some information about your child's urinary and bowl habits.

Many patients see a pediatric urologist for issues related to toileting habits, water intake and bowel habits. In these cases, it will aid in your diagnosis and treatment will begin sooner if you come to your first visit with a voiding diary.

If you are bringing your child to our office for any of the following issues (and your child is potty trained or has completed potty training), the voiding diary is needed for your visit. Please keep the voiding diary meticulously for one week. This will allow me to make better recommendations for your child's care. Many of the terms are similar, but we have included terms used by parents to describe their child's urinary issues.

- Urinary frequency
- Urinary urgency
- Daytime wetting
- Urinary leakage
- Urinary dribbling
- Sensation of dampness after voiding
- Incontinence
- Bedwetting
- Nocturnal enuresis
- Dysuria
- Painful urination
- Hematuria
- Need to urinate soon after urinating.
- Abnormal urinary steam
- Urinary tract infection

Additionally, there is a detailed wetting questionnaire for any patients with wetting issues. Whether daytime, nighttime or both. Filling this questionnaire out in advance will be helpful the day of your visit. This questionnaire is for patients who wish to be seen for the following reasons:

- Wetting
- Dribbling
- Urinary leakage
- Damp underpants
- Bedwetting
- Nocturnal enuresis

Please find the voiding diary and wetting questionnaire, attached. Please complete those that apply.

Sincerely Morristown
Urology Michele
Clement M.D.

261 James Street, Suite 1A • Morristown, NJ 07960 • Tel: 973.539.1050 • Fax: 973.538.6111
*95 Madison Ave, Suite 302 • Morristown, NJ 07960 • Tel: 973.656.0600 • Fax: 973.656.0200
www.muanj.com

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VOIDING DIARY

Week of:	6 AM	7 AM	8 AM	9 AM	10 AM	11 AM	12 PM	1 PM	2 PM	3 PM	4 PM	5 PM	6 PM	7 PM	8 PM	9 PM	10 PM	11 PM	Sleep	B.M.
Monday																				
Tuesday																				
Wednesday																				
Thursday																				
Friday																				
Saturday																				
Sunday																				

Directions:

1. Place a check mark in the box when the patient urinates.
2. Please indicate a "A" for accidents and "D" for damp pants.
3. Please put an "X" in the bowel movement box if your child has a bowel movement.
4. Put a W in the box when your child drinks water. Only water counts as water.

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MORRISTOWN UROLOGY

NIGHTTIME WETTING:

Name: _____

Birthdate: _____ Acct #: _____

Reason for being seen: _____

Does your child have a history of wetting?

Daytime	YES	or	NO
Nighttime	YES	or	NO

DAYTIME WETTING:

How many days a week does your child have daytime wetting? Please circle one response.

1. Less than three days a week
2. Between three and six days a week
3. Everyday

When your child wets, does he/she usually? Please circle one response.

1. Needs to change their clothing
2. Dampens their underwear
3. Just "leaks"

How long has your child had daytime wetting? Please circle one response.

1. Since attempting to toilet train
2. More than twelve months
3. Under twelve months

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MORRISTOWN UROLOGY

NIGHTTIME WETTING:

If your child has nighttime wetting, please estimate episodes per week.

1. Less than three nights a week
2. Between three and six nights a week
3. Every night

When your child wets at night does he/she? Please circle one response.

1. Soak the sheets
2. Dampen the sheets
3. Dampen their pajamas

Does your child wear pull-ups or diapers at night? YES or NO

How long has your child had nighttime wetting? Please circle one response.

1. Since attempting to toilet train
2. More than twelve months
3. Under twelve months

Does your child have a history of urinary tract infections? YES or NO

If yes, does your child experience any of these symptoms? Please circle one response.

1. Burning upon urination
2. Urinating frequently and/or urgency to urinate (void)
3. Foul smell of urine
4. Day or night time wetting only when infected
5. Fever of 101°
6. Other: _____

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MORRISTOWN UROLOGY

Does your child have? Please circle one response.

How long can your child wait after feeling the need to go to the bathroom?
Please circle one response.

1. Can't wait, runs to the bathroom
2. Waits ten to twenty minutes
3. Tries to delay indefinitely
4. Uncertain

How many times in twenty-four hours does your child go to the bathroom to void?
Please circle one response.

1. Less than four
2. Between five and seven
3. Over seven

Does your child have certain rituals to avoid wetting during the day such as squatting, dancing, or grabbing? YES or NO
Is your child's urinary stream? Please circle one response.

1. Continuous (steady)
2. Interrupted (stop/start)
3. Unknown

Will your child go to the bathroom when requested to? Please circle one response.

1. Always
2. Sometimes
3. Never

At what age was your child trained for urine?
Day _____ Night _____ Can't remember_____

At what age was your child trained for B.M.?

_____ Can't remember _____

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MORRISTOWN UROLOGY

Does your child have? Please circle one response.

1. Normal bowel movements
2. Large, hard painful to pass bowel movements
3. Bowel movements or staining in their underwear

How often does your child have bowel movements? Please circle one response.

1. Daily
2. Every other day
3. Every three to four days
4. Once a week

Has your child's bowel movements changed in the last six months? YES or NO

If yes, please explain:

_____

List all family members (oldest to youngest) including child's parents:

Name	Relationship	Sex	Age
_____	_____		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Child's parents are :

___ Married ___ Separated ___ Single ___ Divorced __ Other

Is there any history of wetting in the immediate family?
(parents, aunt, uncle, grandparents, brothers, or sisters)

Daytime *YES or NO*
Nighttime *YES or NO*

If yes, who? _____

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MORRISTOWN UROLOGY

Has your child been previously treated with? Please circle all that apply.

1. Restricting fluids before bedtime
2. Waking your child at night to void
3. Use of a nocturnal alarm
4. Medication
   Imipramine or Tofranil
   DDAVP
   Other _____
5. Psychology

Has this child seen a specialist for this "problem" before? YES or NO

Does this questionnaire sum up your child's history of wetting and/or urinary tract infections?
YES or NO

If no, please explain:

_____

_____

_____