Associates in Pediatric and Adult Urology
The Morristown Medical Center Health Pavilion
333 Mount Hope Avenue – Suite 250
Rockaway, NJ 07866
973-895-6636

Dear New Patient:

Welcome to Associates in Pediatric and Adult Urology, a division of Garden State Urology. Our physicians and staff are dedicated to providing state of the art urological care in a friendly, caring environment. To make your first visit as smooth as possible, we ask that the following forms be completed and sent to us at least **1 day prior 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 with signed Financial Agreement
- 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!

Please remember to arrive 30 minutes prior to your scheduled appointment with the following documents so that your information can be entered into your electronic medical record 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's license, 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 occurred 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. 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. Please have it faxed or emailed to our office, or bring it with you the day of the visit. If you were not referred by another physician or are not presently under the care of a physician that you would like us to correspond with, this document is not necessary.
- **Insurance card(s)**
- **Lab results**, especially blood work and urine cultures and any other tests or medical results that pertain to your visit.
- **Radiology testing** (reports and film/CD) – It is your responsibility to bring these items to your appointment.

If you have a need to reschedule your appointment, please call our office at **973-895-6636** so that we may give that time to another person in need and arrange a more convenient time for you.

Sincerely,

The Scheduling Staff

Central Business Office: 16 Eden Lane, Whippany, NJ 07981 **<>** **Mailing Address:** PO Box 912 Whippany, NJ 07981
Phone: 973.240.2170 <> **Fax:** 973.947.9065

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.

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)____

<u>**Allergies**</u>**:** Please list any drug allergies (including latex and shellfish, if applicable.) Please circle NONE if you do not have any known allergies.

____ **NONE**

<u>**Medications**</u>**:** 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******

<u>**Past Surgical History**</u>**:** 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****

<u>**Past Medical History**</u>**:** Do you have or have you had any of the following medical conditions?

Diabetes	Type 1	Type 2	NO
Asthma		YES	NO
High Blood Pressure		YES	NO
Kidney Stones		YES	NO

Heart Disease		YES	NO
Thyroid Disease	Hyper	Hypo	NO
Cancer If YES please specify:		YES	NO

Arthritis	YES	NO
Indigestion	YES	NO

Other:_______________
____
____

Race (Optional): (Requested by the state of New Jersey for Cancer Registry)

___Caucasian ___African American ___American Indian ___Asian Indian/Pakistani

___Hispanic ___Asian ___Other___________________________________

Height:_____________ **Weight:_________________**

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.**

Constitutional :	None	Fever	Chills	Other:____________________________	
Neurological :	None	Tremors	Dizzy spells	Other:____________________________	
Hematologic/ Lymphatic :	None	Clotting problems	Swollen glands	Blood transfusion	Other:_______________
Musculoskeletal :	None	Joint pain	Neck pain	Other:_____________________________	
Gastrointestinal :	None	Abdominal pain	Nausea/ Vomiting	Other:_____________________________	
Psychological :	None	Depression	Psychosis	Other:_____________________________	
Cardiovascular :	None	Chest pain	Heart attack	Heart murmur	Other:________________
Endocrine :	None	Excessive thirst	Tired/ Sluggish	Diabetes mellitus	Other:________________
Respiratory :	None	Emphysema	Shortness of breath	Other:_____________________________	
Integumentary/ Skin :	None	Skin rash	Persistent itch	Other:_____________________________	
Genitourinary :	None	Urinary tract infection	Blood in urine	Kidney stone	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:_______________**

Atlantic Medical Group

Consult Request Form

Today's consultation with Dr. __________________ is a

request for consultation for ____________________
(Patient name/DOB)

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: 973-895-5327

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

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