



Dear Patient:

Enclosed you will find our registration packet. Our medical providers need these filled out. **ALL** patients of Yakima Urology are required to complete these forms. Thank you.

**YOUR RESPONSIBILITY**

**Registration Forms**

**Please complete these forms and send them back to us as soon as possible *BEFORE* your appointment with us. This will help minimize any delays (OR the rescheduling of your appointment) that you may encounter during the registering process. The prepaid envelope is enclosed for your convenience.**

**CURRENT LIST OF ALL MEDICATIONS**

**Please bring a current list of all medications you are taking or the containers which we can read from.**

**XRAYS**

**Please remember to pick up any x-rays you may have had taken that pertain to urology (ask your referring provider) and bring them with you as well.**

**CO-PAYS AND DEDUCTIBLES:**

If applicable, you will be asked to pay your co-pay and deductible at the time of your visit.

**ALL INSURANCE CARDS / COUPONS**

**Please bring all of your insurance information with you to your appointment. We will copy your insurance cards for your medical records file.**

**REFERRALS:**

For our patients who have an insurance that requires a referral before being seen, it is the patient's responsibility to be sure we have a current referral prior to your visit. Yakima Urology cannot provide medical service to you without the referral. You must obtain your referral from your Primary Care Provider.

Thank you for your cooperation. If you have any questions, please feel free to call us at 509-249-3900 or 1-800-572-8357.

Yakima Urology Associates, PLLC  
2500 Racquet Lane, Ste. 100  
Yakima, WA 98902

Ellensburg Clinic  
700 E. Manitoba  
Ellensburg, WA 98926

Appointment date \_\_\_\_\_ Time \_\_\_\_\_

Your appointment is with:

Dr Merrell     Dr Shively     Dr Gaskill     Dr Lovern     Dr Uhlman

Esther McCorkindale, PA-C     Steven Mack, PA-C     Dyann Kanzler, PA-C

# Yakima Urology Associates, PLLC

## Patient Demographic, Insurance & Signature for Assignment

Date \_\_\_\_\_

<b>PATIENT INFORMATION</b>		<b>Doctor:</b>	<b>ID #:</b>
Name Last:		First:	MI:
		<b>Date of Birth:</b>	
<b>Address:</b>		<b>Social Security #:</b>	
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married / Spouse's Name:
<b>Home Phone #:</b>		<b>Primary Physician:</b>	
<b>Cell Phone #:</b>		<b>Referring Physician:</b>	
<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Interpreter Needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No / <b>Language If Needed:</b>		

<b>PATIENT EMPLOYMENT</b>	<b>CONTACT ( In Case Of Emergency )</b>
<input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled	<b>Name:</b>
<b>Employer:</b>	<b>Phone #:</b>
<b>Phone #:</b>	<b>Relationship To Patient:</b>

<b>PRIMARY INSURANCE</b>	<b>SECONDARY INSURANCE</b>
<b>Name of Subscriber:</b>	<b>Name of Subscriber:</b>
<input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian	<input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian
<b>Birthdate of Subscriber:</b>	<b>Birthdate of Subscriber:</b>
<b>SS # of Subscriber:</b>	<b>SS # of Subscriber:</b>
<b>Employer of Subscriber:</b>	<b>Employer of Subscriber:</b>
<b>Insurance:</b>	<b>Insurance:</b>
<b>ID#:</b>	<b>ID#:</b>
<b>Group#:</b>	<b>Group#:</b>

<b>GUARANTOR ( Responsible Party for minor child)</b> <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
<b>Name:</b>
<b>Date of Birth:</b>
<b>Social Security #:</b>
<b>Phone:</b>
<b>Address:</b>
<b>City:</b> <b>State:</b> <b>ZIP:</b>
<b>Employer:</b>

\*\*\* Signer below also acknowledges that Yakima Urology or its agents, may use all available phone numbers or email address to contact the patient for follow up appointment or to further conduct its business.

Signature of Patient or Person filling out this form: \_\_\_\_\_

Please fill out both pages completely.

**CREDIT POLICY**

All accounts are due and payable in-full within 60 days, unless other arrangements have been made with the Patient Accounts Department. You are responsible for payment of the services rendered by your Physician. As a courtesy to you, we will bill your Primary & Secondary insurances. Since most insurance companies pay less than 100% of actual charges, a 20% payment will be required at time of service unless other financial arrangements are made with the Business Office. If you are without insurance coverage, you will meet with a business office representative to discuss options of payment available to you. **All returned checks will be assessed a \$ 35.00 fee.**

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**INSURANCE COVERAGE & ASSIGNMENT OF INSURANCE PAYMENTS**

I authorize the physician to release information to my Insurance Company for processing claims. I authorize my Insurance Company to make checks payable to you. I request that payment of authorized insurance company reimbursements be made on my behalf to

**Yakima Urology Associates, PLLC**

for any services furnished me. I authorize any holder of medical information about me to release to the CENTER FOR MEDICARE & MEDICAID SERVICES and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**MEDICARE COVERAGE LIFETIME AUTHORIZATION**

1. The Patient, if physically and mentally competent, must sign on his own behalf. If the patient cannot sign, a representative payee as designated by the Social Security Administration or a legally appointed guardian may sign. The source of the signatory's authority should be stated, i.e, Social Security-appointed Representative payee, court appointed-guardian, etc.
2. This form is used in lieu of the patient's signature on the "Request for Payment" form, HCFA 1500, and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction by law, be subjected to fine and imprisonment under Federal Law.

I request that payment of authorized MEDICARE benefits be made on my behalf to

**Yakima Urology Associates, PLLC**

for any services furnished me. I authorize any holder of medical information about me to release to the CENTER FOR MEDICARE & MEDICAID SERVICES, and its agents, any information needed to determine these benefits or the benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**The patient, or minor's parents or guardian is responsible for all charges.**

**YOUR CREDIT MAY BE CHECKED**

# Yakima Urology Associates, PLLC

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Pharmacy Name (please be specific which location): \_\_\_\_\_

What is your reason for being seen? \_\_\_\_\_

Do you require **SBE Prophylaxis** prior to Dental or Surgical procedures? Circle **YES** or **NO**

Do you have **SLEEP APNEA**? Circle **YES** or **NO** \*\*Do you currently use a C-Pap machine? **YES** or **NO**

**CURRENT MEDICATIONS** with dosages. Please include aspirin and any supplements. Please circle

**NONE** if you are not currently taking any medications: **NONE**

**Drug** (full name)

**Strength** and how you take it:

_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES to Medications** (and indicate type of reaction) or **Circle** if – **NO KNOWN ALLERGIES**

## **PAST MEDICAL HISTORY**

Please **Circle** if you **have** or **have had** any of the conditions below or

please circle **NONE** if no conditions apply:

### **CARDIOVASCULAR: NONE**

Anemia	Sickle Cell Anemia	Carditis Date: _____	CAD
Angina (chest pain)	Deep Vein Thrombosis Date: _____	Hemophilia Type: _____	
Arrhythmia (Irregular heartbeat)	Congestive Heart Failure	High blood pressure	
Heart Murmur	Heart Attack Date: _____	Heart Disease (specify) _____	
Leukemia	Rheumatic Fever	Bleeding disorder (specify) _____	
Stroke Date: _____	Valve disorder Type: _____	OTHER: _____	

**ENDOCRINE/METABOLIC:** Diabetes **CIRCLE ONE**: Insulin **or** Oral Med Gout

Thyroid Disorder **CIRCLE ONE**: Hyperthyroidism **or** Hypothyroidism

OTHER: \_\_\_\_\_

### **GENERAL: NONE**

Exposure to chemicals Specify: \_\_\_\_\_ Hepatitis   A   B   C Date: \_\_\_\_\_

Hypercholesterolemia Hyperlipidemia Paget's Disease PCKD Raynaud's Syndrome

Infectious Disease: \_\_\_\_\_ OTHER: \_\_\_\_\_

**GASTROINTESTINAL: NONE**

Cholecystitis (Gallbladder) Colitis Constipation Crohn's Disease Colon Polyps: Benign or Cancerous  
Diverticulosis GERD/Reflux Hemorrhoids Fissures Hiatal Hernia  
Irritable Bowel Disease Liver Disease Pancreatitis Ulcerative Colitis Ulcers (specify) \_\_\_\_\_  
OTHER: \_\_\_\_\_

**GENITOURINARY: NONE**

Acute Prostatitis AIDS Date diagnosed: \_\_\_\_\_ Benign Prostatic Hypertrophy (BPH) Bladder Stone  
Bladder infection Chronic Prostatitis Elevated PSA Interstitial Cystitis Recurrent UTI  
Kidney Disease (specify) \_\_\_\_\_ Kidney Stones Kidney failure  
Transplant Recipient Type: \_\_\_\_\_ Date: \_\_\_\_\_  
OTHER: \_\_\_\_\_

**HEENT: NONE**

Cataracts Glaucoma Narrow/Closed or Wide/Open Hay Fever Mumps Sinusitis Vertigo  
OTHER: \_\_\_\_\_

**MUSCULOSKELETAL: NONE**

Arthritis Back Pain Carpal Tunnel Syndrome Fibromyalgia Morton's Neuroma  
OTHER: \_\_\_\_\_

**NEUROLOGICAL/PSYCHOLOGICAL: NONE**

ADD ADHD Alzheimer's Disease Anxiety Disorder Bi-polar Disorder  
Depression Alcoholism Epilepsy Seizure Disorder Migraines Multiple Sclerosis  
Parkinson's Disease Spinal Cord Injury Date: \_\_\_\_\_ Suicide Attempt  
OTHER: \_\_\_\_\_

**RESPIRATORY: NONE**

Asthma Bronchitis COPD Emphysema  
Pneumonia Pulmonary Embolism Date: \_\_\_\_\_ Tuberculosis  
OTHER: \_\_\_\_\_

**TUMORS: NONE**

CANCER TYPE: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_  
Treatment dates: \_\_\_\_\_ Treatment types: \_\_\_\_\_

**PREVIOUS SURGERIES NONE**

Date	Type of Surgery (Specify Left or Right, if Applicable)	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

**SEXUAL HISTORY**

Sexual Activity:                      None                      Active, single partner                      Active, multiple partners

Sexually Transmitted Diseases **TYPE:** \_\_\_\_\_

Sterilization Type: \_\_\_\_\_ Date: \_\_\_\_\_ Contraceptives: \_\_\_\_\_

**GYN/OB**

Breast Cancer                      Breast Disease                      Endometriosis                      Menstrual problems                      Osteoporosis

Ovarian cyst                      Uterine fibroids                      \_\_\_\_\_ number of pregnancies                      \_\_\_\_\_ number of births

\_\_\_\_\_/\_\_\_\_ # of miscarriages/abortions                      Postmenopausal When: \_\_\_\_                      Prior Abnormal Pap: **NO**                      **YES**

**Hysterectomy**                       Complete                       Partial

**FAMILY HISTORY**

**Major medical problems of family members (such as heart disease, diabetes, high blood pressure):**

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Brothers: \_\_\_\_\_ Sisters: \_\_\_\_\_

Other major illnesses in Family: \_\_\_\_\_ Which member(s)? \_\_\_\_\_

Family history of Cancer (What type and which family member): \_\_\_\_\_

**SOCIAL HISTORY**

Marital Status:

Single \_\_\_\_ Married \_\_\_\_ years Divorced \_\_\_\_ years Widowed \_\_\_\_ years Other (specify): \_\_\_\_\_

Number of children: Sons \_\_\_\_ Daughters \_\_\_\_ Stepchildren \_\_\_\_\_

Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Alcohol Consumption:                      Do not drink                      Occasional/Social                      Number of Drinks/day \_\_\_\_\_

Tobacco use:                      Do not smoke                      \_\_\_\_ packs/day for \_\_\_\_ years                      smokeless \_\_\_\_\_

Quit Smoking:                      When \_\_\_\_\_                      How much? \_\_\_\_ packs/day for \_\_\_\_ years

Recreational Drugs:                      None                      If yes, please list: \_\_\_\_\_

Caffeinated beverages:                      NONE                      LOW                      MODERATE                      EXCESSIVE

Recent Foreign Travel:                      None                      Americas \_\_\_\_\_ Worldwide \_\_\_\_\_

**Yakima Urology Associates, PLLC**

**REVIEW OF SYSTEM**

Are you **currently** experiencing any problems relating to the following systems? **Circle YES OR NO** below.

**Constitutional**

Fever YES NO  
 Chills YES NO  
 Insomnia YES NO  
 Other: \_\_\_\_\_

**Eyes**

Blurred Vision YES NO  
 Double Vision YES NO  
 Pain YES NO  
 Other: \_\_\_\_\_

**Allergic / Immunologic**

Seasonal Allergies YES NO  
 Animal Fur YES NO  
 Food YES NO  
 Other: \_\_\_\_\_

**Neurological**

Tremors YES NO  
 Dizzy Spells YES NO  
 Numbness / Tingling YES NO  
 Headache YES NO  
 Other: \_\_\_\_\_

**Endocrine**

Excessive Thirst YES NO  
 Heat /Cold intolerance YES NO  
 Abnormally Tired/Sluggish YES NO  
 Other: \_\_\_\_\_

**Gastrointestinal**

Abdominal Pain YES NO  
 Nausea / Vomiting YES NO  
 Indigestion / Heartburn YES NO  
 Rectal bleeding YES NO  
 Other: \_\_\_\_\_

**Cardiovascular**

Chest Pain/Angina YES NO  
 Palpitations YES NO  
 High Blood Pressure YES NO  
 Other: \_\_\_\_\_

**Additional comments:**

**Integumentary**

Skin Rash YES NO  
 Boils YES NO  
 Persistent Itch YES NO  
 Pigment changes YES NO  
 Other: \_\_\_\_\_

**Musculoskeletal**

Joint Pain YES NO  
 Neck Pain YES NO  
 Back Pain YES NO  
 Other: \_\_\_\_\_

**Ear / Nose / Throat / Mouth**

Ear Infection YES NO  
 Sore Throat YES NO  
 Sinus Problems YES NO  
 Other: \_\_\_\_\_

**Genitourinary**

Urine Retention YES NO  
 Painful Urination YES NO  
 Urinary Frequency YES NO  
 Other: \_\_\_\_\_

**Respiratory**

Wheezing YES NO  
 Frequent Cough YES NO  
 Shortness of Breath YES NO  
 Other: \_\_\_\_\_

**Hematologic / Lymphatic**

Swollen Glands YES NO  
 Blood Clotting Problem YES NO  
 Other: \_\_\_\_\_

**Psychologic**

Are you generally satisfied with your life?  
 YES NO

Do you feel depressed?  
 Rarely Occasionally Most of the time

Other: \_\_\_\_\_

Yakima Urology Associates, PLLC  
2500 Racquet Lane, Suite 100  
Yakima, WA 98902  
(509)249-3900 Fax (509) 573-9539

## **Authorization to Release Medical Information with Designated Individuals**

Do you give Yakima Urology Associates, PLLC permission to discuss and/or release your medical information with family members/caregiver?

**YES**  **NO** If yes, please provide complete information below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If you have an answering machine at home may we leave messages containing medical information, such as scheduling and prescription issues?

**YES**  **NO**

\_\_\_\_\_  
**Signature of Patient/Legal Guardian**

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Print First and Last Name

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date and Time

This authorization may be revoked in writing at any time. However, a revocation would not affect any actions already taken by Yakima Urology Associates, PLLC based upon this authorization. Proof of identification will be needed for verification.

# International Prostate Symptom Score (I-PSS)

## FOR MEN OVER 40 ONLY

Patient Name: \_\_\_\_\_ Account #: \_\_\_\_\_

Date: \_\_\_\_\_ Physician: \_\_\_\_\_

To use this symptom scorecard: Circle one number in each line and add up all circled numbers to get the total score. The total runs from 0 to 35 points with higher scores indicating more severe symptoms. Scores less than seven are considered mild and generally do not warrant treatment.

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
<b>Incomplete Emptying</b> 1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5
<b>Frequency</b> 2. Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
<b>Intermittency</b> 3. Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
<b>Urge to Urinate</b> 4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
<b>Weak Stream</b> 5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
<b>Straining</b> 6. Over the past month, 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 or more
<b>Urinating at Night</b> 7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5
<b>Symptoms Score: 1-7 Mild, 8-19 Moderate, 20-35 Severe</b>	Total: _____					

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
<b>Bothersomeness of Urinary Symptoms</b> How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life.	0	1	2	3	4	5	6