Arizona State Urology, PLLC

(Subsidiary of Glendale Urology, PC)

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES					
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)			ADDRESS		
CITY, STATE		ZIP	HOME PHONE		CELL PHONE
BIRTHDAY (M/D/Y)	PATIENT SSN	SEX ❑ Male ❑ Female ❑Other_____	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____		EMAIL (REQ-PORTAL)
PATIENT EMPLOYER NAME		PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)			EMPLOYER PHONE
INSURED/RESPONSIBLE PARTY INFORMATION		RELATION TO PATIENT: ❑spouse ❑parent ❑guardian			
NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER	
INSURANCE INFORMATION					
PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)		PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
PRIMARY DOCTOR/FAMILY DOCTOR		REFFERING DOCTOR			
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP	PHONE NUMBER		

ASSIGNMENT AND RELEASE (Please Initial Before Each Line):

_____ I understand that I have medical insurance which when billed on my behalf should pay for their portion of my office visits and treatment charges.

_____ I will inform Arizona State Urology, P.L.L.C. or Ironwood Physicians, PC of a change in my insurance coverage.

_____ I understand the billing process may take 4-6 weeks at which time my insurance company will determine and pay for services per my contract.

_____ I understand that it is my responsibility to pay all co-pay, deductible and estimated co-insurance amounts at the time of service rendered and remaining balance as determined by my insurance company.

_____ I understand that if for any reason my insurance company does not pay for the covered services within 90 days of the services provided, I shall assume responsibility for the total amount owed, which may be charged to the credit card on file.

_____ I thereby assign all medical benefits directly to Ironwood Physicians, PC for services rendered at their facilities.

_____ I understand if a CT or PET/CT scan is completed it will be necessary for a licensed Radiologist to interpret or read my scan results. I will receive two statements for my CT or PET/CT scan. One for the professional interpretation of the CT or PET/CT scan which is separate from Ironwood.

_____ We may request proof of insurance premium payment.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	Date

Authorization to release health information to:

Name-Emergency Contact (s)	ADDRESS		
CITY, STATE	**ZIP**	**HOME PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER** **DATE:**		

Release the following information:

❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

Name-Additional Contact (s)	ADDRESS		
CITY, STATE	**ZIP**	**HOME PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER** **DATE:**		

Release the following information:

❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

RELEASE OF INFORMATION

I understand that:

- Once Arizona State Urology, PLLC and/or Ironwood Physicians, PC discloses my health information by my request, we cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- I hereby authorize Arizona State Urology, PLLC and Ironwood Physicians, PC to use and disclose my personal health information to the individuals identified on this form. I understand this authorization does not expire unless written notice is mailed to P.O. Box 6423 Chandler AZ, 85246. I understand this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist. I understand that Ironwood Physicians PC will treat the individuals identified on this form as individuals involved directly in my care and as such, Ironwood Physicians, PC will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations. I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Arizona State Urology, PLLC and/or Ironwood Physicians PC will not be affected if I refuse to sign this authorization.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**	

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that:

- Arizona State Urology, PLLC and Ironwood Oncology, PC share the same commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

- I acknowledge that I have received a copy of the Notice of Privacy Practices of Ironwood Oncology, P.C.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**	

Arizona State Urology

Patient History Form

To prevent medical errors it is critical you complete this form completely and accurately!

First Name: _____ Last Name: _____ DOB: _____ Date: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____ Preferred Lab: _____

Height: _____ ft _____ in Weight: _____ lbs Age: _____ Occupation: _____

Race: _____ Primary Language: _____ Ethnic Group: _____

How did you hear about our practice:

☐ Referring Physician ☐ Friend ☐ Internet (which site?) _____ ☐ Insurance Company ☐ Other, How? _____

Name of Physician who referred you to this Office: _____

Current Physicians	Address	Phone #	Fax #	Specialty

CHIEF COMPLAINT *(Why do you want to see the doctor?)* _____

How long have you had this complaint? _____

MEDICATIONS *(List all **Prescription** drugs you are taking with dosage and schedule)* ☐ See Attached List

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

*List all **Non-Prescription** drugs:*

Vitamins: _____ Aspirin / Ibuprofen: _____

Other (including supplements): _____

ALLERGIES *(List all allergies to drugs or foods (i.e., sulfa, shellfish))* ☐ No Known Allergies ☐ See Attached List

_____

PATIENT HISTORY *(Do you have any of the following:)*

Asthma ---------- □ Yes □ No
Atrial Fibrilation ---------- □ Yes □ No
Cancer ---------- □ Yes □ No
Type: _____
CVA / Stroke ---------- □ Yes □ No
Depression ---------- □ Yes □ No
Diabetes ---------- □ Yes □ No
DVT ---------- □ Yes □ No
Glaucoma ---------- □ Yes □ No
Heart Disease ---------- □ Yes □ No
Hepatitis ---------- □ Yes □ No
Hyperlipidemia ---------- □ Yes □ No
Hypertension ---------- □ Yes □ No
Liver Disease ---------- □ Yes □ No
Myasthenia Gravis ---------- □ Yes □ No
Neurologic Disorder ---------- □ Yes □ No
Osteoarthritis ---------- □ Yes □ No
Peripheral Vascular Disease ---------- □ Yes □ No
Thyroid Disorder ---------- □ Yes □ No
Tuberculosis ---------- □ Yes □ No
UTI Recurrent ---------- □ Yes □ No
Vascular Disease ---------- □ Yes □ No
No Medical Problems ---------- □ Yes □ No

Other Medical Problems: _____

_____

PREVIOUS SURGERIES: □ Yes □ No If yes, please complete the below.

Type	Date	Type	Date

Previous Hospitalizations for Medical Problems: □ No □ Yes. If yes, type and date: _____

_____

FAMILY HISTORY *(Please fill out as complete as possible – # of children, status, check boxes)*

	Status (Alive/Dead)	Age	Prostate Cancer	Kidney Cancer	Bladder Cancer	Breast Cancer	Diabetes	High Blood Pressure	Heart Disease
Daughters (#)			☐	☐	☐	☐	☐	☐	☐
Sons (#)			☐	☐	☐	☐	☐	☐	☐
Father	A/D		☐	☐	☐	☐	☐	☐	☐
Mother	A/D		☐	☐	☐	☐	☐	☐	☐
Grandparent			☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐
Other Family History?:									

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Children: ☐ Yes ☐ No Boys _____ Girls _____

Exercise?. . . . . ☐ Yes ☐ No Type: _____

Current Tobacco use? . . . . ☐ Yes ☐ No Prior Tobacco use? ☐ Yes ☐ No

Alcohol use? . . . . . ☐ Yes ☐ No Current Drug use? ☐ Yes ☐ No Type: _____

Caffeine use? (Cups / Day): Coffee: _____ Tea: _____ Cola: _____

REVIEW OF SYSTEMS (Have you currently or recently had)

General
Fatigue □ Yes □ No
Fever □ Yes □ No
Weight Gain □ Yes □ No
Weight Loss □ Yes □ No

Allergy
Drug Allergies □ Yes □ No
Seasonal Allergies □ Yes □ No

Opthalmologic
Blurred Vision □ Yes □ No

ENT
Dry Mouth □ Yes □ No
Nosebleeds □ Yes □ No

Endocrine
Cold Intolerance □ Yes □ No
Excessive Sweating □ Yes □ No
Heat Intolerance □ Yes □ No

Respiratory
Shortness of Breath □ Yes □ No

Cardiovascular
Chest Pain □ Yes □ No
Edema (swelling) □ Yes □ No

Gastrointestinal
Constipation □ Yes □ No
Diarrhea □ Yes □ No
Nausea □ Yes □ No

Hematology
Bleeding Problems □ Yes □ No

Musculoskeletal
Back Pain □ Yes □ No
History of Gout □ Yes □ No

Peripheral Vascular
Blood Clots in Legs □ Yes □ No

Skin
Rashes □ Yes □ No

Neurologic
Leg or Arm Weakness □ Yes □ No
Balance Difficulty □ Yes □ No
Headaches □ Yes □ No

Psychiatric
Depressed Mood □ Yes □ No

Date of Last:
Flu Shot _____
Varicella _____
Colonoscopy _____
Dexa Scan _____

Females
Mammogram _____
Annual Pap _____

Form Completed By: _____ Date: _____

Arizona State Urology

Patient Identifying Information:

Patient Name: _____ Date of Birth: _____

Address: _____City_____ State_____ Zip Code_____

Phone Number: _____ Date (s) of Service(s): ALL Medical Records

Release of medical records to Arizona State Urology:

I authorize Affiliated Urologists- Arizona Oncology - **Phone: 602 264-0608** **Fax: 602 234-0417**

to release my medical records as I have indicated in **Section 2:**

Disclose to: Arizona State Urology

Address: 6525 W. Sack Drive Suite 201 Glendale, AZ 85308

Phone: 602 337-8500 **Fax: 602 337-8151**

2. **Specific Description of Information to Be Disclosed** (check all that apply):

_____ Discharge Summary, History and Physical Exam, Operative Reports, Consultation reports

_____ X-ray Reports, Pathology, Lab Testing, Progress Notes

_____ Pertinent Records Only Other (Specify)_____

Specific description of the purpose of disclosure:

_____ The disclosure is at the patient's request Other(Specify)_____

I authorize the provider to use or disclose information related to:

_____ AIDS/HIV _____ Genetic Testing Information

_____Psychiatric Care Reports _____ Alcohol and/or Drug Abuse Treatment

I understand that Arizona State Urology, PC will not condition on my signing this authorization. Arizona State Urology, PC will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time with some exceptions. For more details on when I can or cannot revoke this authorization, I can read Arizona State Urology, PC Notice of Privacy Practices.

To revoke my authorization, I must submit written request to Arizona State Urology, PC. Unless I revoke the authorization earlier, it will expire upon its completion or 180 days from the date of signature, whichever comes first. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulation and may be re-disclosed by the person or organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associated to the extent indicated and authorized herein.

Signature of Patient: _____ Date: _____

Signature of Legal Representative: _____ Relationship to Patient: _____