Centura Health Physician Group
Urology Castle Rock
Centura Health.

Initial Intake Form

Patient Information

Your name (exactly as it appears on your insurance card or policy for billing purposes):

Last _____ First _____ Middle _____

Common name or nickname you would like to be called when we see you: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Which phone number is your primary contact number? _____

Please initial if it is alright to leave a detailed message with health information on your voice mail: _____

Email: _____ Marital Status: _____ SSN: _____-_____-_____

Race: Check One:

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Declined

Ethnicity:

Do you consider yourself to be Hispanic or Latino? ☐ Y ☐ N
☐ Declined

Religion: _____ ☐ Declined Primary Language: _____

Primary Care Physician: _____ Physician Phone Number: _____

Referring Physician (if other than PCP): _____ Referring Physician Phone#: _____

Employer: _____ Occupation: _____

Phone: _____ Check Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Student ☐ Retired

Employer Address: _____

Emergency Contact (Spouse or Next of Kin)

Name: Last _____ First _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Address (optional): _____

Do we have your permission to leave personal medical information with your emergency contact? ☐ Yes ☐ No

Please list any other persons you authorize the clinic to leave personal medical information with: (optional)

Name: _____ Relation: _____

Name: _____ Relation: _____

Guarantor Information (person responsible for payment)

☐ Self (skip to next section)

Name: Last _____ First _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Guarantor SSN: _____-_____-_____ Relationship to Patient: _____

Employer: _____ Employment Status: _____

Employer Address: _____

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Primary Insurance Information

Insurance Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Member ID/Policy #: _____ Group: _____ Copay: _____
Policy Holder: ☐ Self (skip to next section)
Name: Last _____ First _____ Middle Initial _____
Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Sex: ☐ M ☐ F
Address: _____ City: _____ State: _____ Zip: _____
Relationship to patient: _____

Secondary Insurance Information

Insurance Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Member ID/Policy #: _____ Group: _____ Copay: _____
Policy Holder: ☐ Self (skip to next section)
Name: Last _____ First _____ Middle Initial _____
Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Sex: ☐ M ☐ F
Address: _____ City: _____ State: _____ Zip: _____
Relationship to patient: _____

How did you hear about our practice?

☐ Friend/Family ☐ Online ☐ Yellow Pages

☐ Doctor: _____

Deductibles, co-payments, or co-insurance and payments for non-covered services are required at the time of service. Our office will only file a claim with an insurance company with whom we have a contract. I understand that accounts more than 90 days past due may be turned over to collections and any legal fees or costs will be my responsibility. I authorize my insurance benefits to be paid directly to the treating provider, realizing I am responsible to pay non-covered and unauthorized services and I hereby authorize the release of pertinent medical information to insurance carrier.

Signature: _____ Date: _____ Time: _____
(Patient or Authorized Representative)

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Name: _____ Date of Birth: _____/_____/_____

Surgical History

Year	Surgery/Procedure	Hospital/Location	Complications/Additional Comments

Have you ever had a reaction to general anesthesia? □ Yes □ No

Family History: Please check the box below for "yes"

Do family members have a history of:

□ Kidney Stones	□ Prostate Cancer	□ Heart Disease	□ Diabetes
□ Kidney Disease	□ Breast Cancer	□ Stroke	□ Blood Clots
□ Kidney Cancer	□ Other Cancer(s)		

Social History:

Smoking: YES or NO Packs per day: _____ # of Years: _____ Quit Date: _____
Alcohol: YES or NO Beverage: _____ # per day/week: _____ Quit Date: _____
Illicit Drugs: YES or NO Drugs Used: _____ Quit Date: _____
Tattoos: YES or NO
Exercise: YES or NO

Sexual Activity:

□ Not Active □ Active

Number of lifetime sexual partners: _____ □ Men □ Women □ Both

Number of Pregnancies: _____ Number of children born: _____

Other Pertinent Information:

_____

_____

_____

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Name: _____ Date of Birth: _____/_____/_____

Pharmacy:

Pharmacy: _____ Phone: _____

Pharmacy Location: _____

Medications:

Prescription Medication

Name of Medication	Dose	Frequency	Reason for Medication

Over The Counter Medication and Herbal Supplements

Name of Medication	Dose	Frequency	Reason for Medication

Allergies:

Please list all your medication allergies

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UROLOGY HISTORY FORM

Name: _____ Date of Birth: _____/_____/_____

Chief Complaint:

What is the main reason for your visit today: _____

When did you first notice the problem: _____

How long does the problem last: _____

Does anything help or make it worse: _____

Symptoms:

- On average, how many times a DAY do you urinate: _____
- On average, how many times during the NIGHT do you urinate: _____
- During a typical day, how many protective pads do you wear: _____
  - Are they: Damp_____ Wet_____ Soaked_____
  - What type of pads are you using: Light Days___ Mini___ Maxi___ Poise___ Depends___
- Do you leak urine at night in bed: (enuresis) □ Yes □ No
- Do you have such a strong urge to urinate that you leak urine: (urgency) □ Yes □ No
- Do you leak urine when you sneeze, cough, laugh or exercise: (stress incontinence) □ Yes □ No
- Do you have to strain to get urine stream started: (straining) □ Yes □ No
- Do you often have to stop and start again several times when you urinate: (intermittency) □ Yes □ No
- Do you often have to wait a while before you start to urinate: (hesitancy) □ Yes □ No
- Do you feel like you empty your bladder: (incomplete empty) □ Yes □ No
- Do you have a weak urinary stream: (weak stream) □ Yes □ No
- Have you ever had bladder or kidney infections: (UTIs) □ Yes □ No
- Have you had blood in your urine: (hematuria) □ Yes □ No
- Do you experience pain or discomfort when you urinate: (dysuria) □ Yes □ No
- Do you have abdominal or flank pain: (flank pain) □ Yes □ No
  - Is it: Mild___ Moderate___ Severe___ On scale of 1 to 10, what is your pain number: _____
- Have you seen bubbles in your urine: (pneumaturia) □ Yes □ No
- Have you had recent difficulties with your sex life: (ED, anorgasmia) □ Yes □ No
  - Erection Problem_____ Orgasm Problem_____

Thank you for choosing **Urology Castle Rock**!
We appreciate your trust in us to take care of your urology needs.