The Center For Men's and Women's Urology

Shammai Rockove, M.D. F.A.C.S. / Melanie Crites-Bachert, D.O. F.A.C.O.S. F.A.C.S.

Completing all forms in their entirety and faxing, mailing or dropping them off will decrease your wait time at our office for your appointment.

New patient appointments that are missed without notice will not be rescheduled.

Personal Information:

Patient Name:		
Social Security#:	D.O.B.	Sex:
Preferred Language*:	Race*:	Ethnicity*:
Emerg. Contact:	Phone#:	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____		
Spouses Name:	Consent to speak with spouse? ☐ Y ☐ N	

Preferred Pharmacy:

Name:	Intersection or Street Address and City:

Mailing Address:	Second Address:
Street:	Street:
City, State, Zip:	City, State, Zip:
E-mail Address:	

Insurance Information:

Primary Insurance:	Secondary Insurance:
I.D. #:	I.D. #:
Group #:	Group #:
Ins. Address:	Ins. Address:
Insured's Name and DOB (if not self)	Insured's Name and DOB (if not self)

I wish to be contacted in the following manner (please indicate all that apply):

Home Phone #:	Ok to leave detailed message? Yes or No
Mobile Phone #:	Ok to leave detailed message? Yes or No
Consent to text mobile phone? ☐ Y ☐ N	Preferred contact: ☐ Home ☐ Mobile ☐ Email
CFMWU has my permission to share my medical information with (name and relation):	

Primary Care Physician:	**Referred By:**

Signature of Patient _____ Date _____

*The Federal Government requires The Center for Men's and Women's Urology to gather certain demographic information

Please be prepared to leave a urine specimen at every appointment.

24076 SE Stark Street, Suite 310 Gresham, OR 97030 / tel: 503-492-6510 fax: 503-492-6502 / www.1URO.com

Patient Name: _____

Please initial each "_____"

_____ **ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I request that payment of authorized benefits (Medicare, managed HMOs/IPAs and/or insurance companies) be made either to me or on my behalf to The Center for Men's and Women's Urology for any services furnished to me by my provider. I authorized any holder of medical information about me to release it to the following when applicable to determine benefits for related services:

Division of Family Services
Centers for Medicare and Medicaid Services
Insurers and/or agents of these companies
Responsible person(s) listed
Other healthcare providers assisting in my medical care

_____ **CONSENT TO TREATMENT**

I hereby authorize The Center for Men's and Women's Urology and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

_____ **FINANCIAL AGREEMENT**

I understand unless other arrangements have been made in advance by either me or my health coverage carrier, payment in full is due at the time of service. Acceptable methods of payment are cash, personal checks, VISA, MasterCard, Discover Card, AMEX or Care Credit.

The Center for Men's and Women's Urology is contracted with many health plans. We will submit a claim to those plans for which we are contracted with and will require you to pay the authorized co-payment, deductible, and/or co-insurance at the time of service. It is our office policy to collect any unmet deductible and/or coinsurance at check-in. Every attempt will be made to notify you in advance as to the amount that will be collected.

If you have any questions or concerns regarding your coverage for procedures, screenings services, medications or particular conditions, you are responsible for obtaining this information prior to your appointment from your health plan. You agree to pay in full for all services considered "non- covered" services per your insurance policy if you choose to have the service provided.

If your insurance company does not pay for the services provided, or you do not have insurance, you agree to pay all charges of The Center for Men's and Women's Urology. Each bill is due and payable upon presentation or mailing of a statement to you. Should the account become delinquent, you agree to pay all costs of collection applied by a collection agency. Any suit filed may be brought in the county where the services are rendered.

You have the right to receive a good faith estimate for total expected costs upon request.

_____ **PHYSICAL FORM COMPLETION**

I understand if I, or a person/entity on my behalf, request The Center for Men's and Women's Urology to complete a disability, FMLA paperwork, home health, or other physical form, the practice will assess me a $25 fee for simple and $40 for detailed paperwork. Please allow 48 hours to complete.

_____ **CANCELLATION POLICY**

I understand I will be assessed a $50 fee for Office Visits, $100 fee for in-office procedures and a $200 fee for hospital surgeries by The Center for Men's and Women's Urology, per their Cancellation Policy, if I:

Do not show up for my appointment
Do not cancel my appointment with a minimum of 24-hour notice
Do not cancel my surgery 3 business days in advance

_____ **RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT**

I have received a copy of, or viewed online at www.1URO.com, The Center for Men's and Women's Urology Notice of Privacy Practices

_____ **OTHER**

I understand that a $25 fee will be charged for any NSF checks in addition to any bank fees

We reserve the right to terminate you as a patient due to non-compliance, transferring care to another urologist, missing surgical appointments and/or multiple missed appointments.

I understand and agree to all of the above:

_____ _____

Signature of Patient (For patients 17 years of age or younger, a parent or guardian MUST sign) **Date**

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Patient Name: _____ **Date:** _____ **Date of Birth:** _____

Chief Complaint (briefly describe your primary urological problem): _____

Have you seen a urologist before? Yes or No _____

Medical Problems:

1	2
3	4
5	6

Previous Surgeries with Dates:

1	2
3	4
5	6

Medications You Take and Reason:

1	2
3	4
5	6

***We can refill your vitamins and have them shipped to you. Let us know when you check in if you would like this service.**

Allergies You Have:

1	2
3	4
5	6

Patient Social History. Please check those that apply to you and indicate quantity if applicable:

Caffeine Intake?	Recreational Drugs?	How often do you exercise?
Drink Alcohol?	Tobacco Use?: Y/N ☐ Current ☐ Previous How long?: _____ ☐ Cigarettes ☐ Chewing Tobacco ☐ Other:_____	

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Other: _____

Employed?: ☐ Yes ☐ No Occupation:

Family History. Indicate who has/had (F=Father; M=Mother; B=Brother; S=Sister; GF=Grandfather; GM=Grandmother; A=Aunt; U=Uncle)

Is your father alive?: Y/N	Is your mother alive?: Y/N	Do you have children?: Y/N How Many?	
Heart Disease	Mental Illness	Cancer	Bleeding Disorder
Stroke	Epilepsy/Convulsions	Diabetes	Kidney Disease
Prostate Cancer	High Blood Pressure	Thyroid Disease	

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C FM WU The Center For Men's and Women's Urology

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Patient Name: _____ Date: _____ Date of Birth: _____

Please check and briefly describe if you now have, or have had, any of the following:

Y	N	General
☐	☐	fevers
☐	☐	chills
☐	☐	sweats
☐	☐	weight loss
☐	☐	weight gain
☐	☐	tiredness

Y	N	Eyes
☐	☐	blurring
☐	☐	double vision
☐	☐	irritation
☐	☐	discharge
☐	☐	vision loss
☐	☐	eye pain

Y	N	Ear/Nose/Throat
☐	☐	earache
☐	☐	ear discharge
☐	☐	decreased hearing
☐	☐	nasal congestion
☐	☐	nose bleeds
☐	☐	sore throat
☐	☐	hoarsness
☐	☐	nasal obstruction/discharge

Y	N	Cardiovasclar
☐	☐	chest pain
☐	☐	palpitations
☐	☐	swelling of lungs

Y	N	Heme/Lymphatic
☐	☐	abnormal bruising
☐	☐	bleeding
☐	☐	enlarged lymph nodes

Y	N	Respiratory
☐	☐	cough
☐	☐	shortnes of breath
☐	☐	wheezing

Y	N	Gastrointestinal
☐	☐	nausea
☐	☐	vomiting
☐	☐	diarrhea
☐	☐	constipation
☐	☐	change in bowel habits
☐	☐	abdominal pain

Y	N	Genitourinary
☐	☐	pain with urination
☐	☐	blood in urine
☐	☐	discharge
☐	☐	urinary frequency
☐	☐	urinary hesitancy
☐	☐	urine leakage
☐	☐	urinary urgency
☐	☐	slowing urinary stream
☐	☐	genital sores
☐	☐	impotence
☐	☐	decreased libido
☐	☐	erection difficulty

Y	N	Skin
☐	☐	rash
☐	☐	itching
☐	☐	dryness
☐	☐	lumps
☐	☐	sores

Y	N	Allergic/Immunologic
☐	☐	hives
☐	☐	persistent infections

Y	N	Musculoskeletal
☐	☐	back pain
☐	☐	joint pain
☐	☐	joint swelling
☐	☐	muscle cramps
☐	☐	muscle weakness
☐	☐	joint stiffness

Y	N	Psychiatric
☐	☐	depression
☐	☐	anxiety
☐	☐	memory loss
☐	☐	suicidal ideation
☐	☐	hallucinations
☐	☐	difficulty sleeping

Y	N	Neurologic
☐	☐	weakness
☐	☐	seizures
☐	☐	fainting
☐	☐	tremors
☐	☐	lightheadedness
☐	☐	numbness
☐	☐	headaches

Y	N	Endocrine
☐	☐	cold intolerance
☐	☐	heat intolerance
☐	☐	excesive thirst
☐	☐	weight change

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