



Urology Consultants, Ltd.

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Welcome to our practice. To simplify the process on your first visit please complete the enclosed patient information forms prior to your arrival. Additionally, you will need to present a current insurance card upon your arrival. If your insurance requires a referral from your primary care physician it is your responsibility either to bring it with you, or to insure that it has been transmitted to us. We strongly encourage you to contact your insurance carrier to determine whether or not you need a referral for your visit to the urologist.

In order to help maintain health care costs we require all co-pays at the time of check-in. If you wish to acquaint yourself with our practice you may visit our website at www.ucl-stl.com.

We look forward to seeing you.

Sincerely,

The physicians and staff at Urology Consultants, Ltd.



Urology Consultants, Ltd.

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I. _____
 Address: _____ City: _____ State/Zip: _____
 Home Phone: _____ Cell: _____
 Social Security #: _____ Date of Birth: _____ Marital Status: _____
 Employer/Occup: _____ Employer Phone: _____ Gender: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

HEALTH INSURANCE INFORMATION – A Copy of Your Health Insurance Card(s) is Required

PRIMARY Coverage

Insurance Company: _____
 Subscriber/Card Holder/Policy Owner: _____
 Subscriber's Date of Birth: _____
 Subscriber's Relationship to Patient: _____

SECONDARY Coverage

Insurance Company: _____
 Subscriber/Card Holder/Policy Owner: _____
 Subscriber's Date of Birth: _____
 Subscriber's Relationship to Patient: _____

Primary Care Physician: _____ **Phone:** _____
Referring Physician: _____ **Phone:** _____
Pharmacy Name: _____ **Phone:** _____

AUTHORIZATION

I hereby authorize this office to furnish information to insurance carriers concerning this illness/accident and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance or workers compensation. I hereby authorize photocopies of this authorization form to be valid as the original. I consent to disclosure of my medical information to outside agencies for the purpose of providing healthcare services to me. If I fail to obtain a referral, I understand that I am financially responsible. I acknowledge that I have received the mandatory information regarding "Notice of Privacy Practices." (HIPAA)

X SIGNATURE: _____ **Date:** _____

AUTHORIZATION TO RELEASE INFORMATION (Your Signature is Required)

Do You Authorize Another Person To Receive Your Medical Information? Yes No

If YES, Who _____ Relationship to Patient _____

Do You Authorize Another Person To Receive Your Billing Information? Yes No

If YES, Who _____ Relationship to Patient _____

Do You Authorize Urology Consultants to Leave Patient Test Results on an Answering Machine or Voice Mail: Yes No If YES, at which phone number(s)? _____

X SIGNATURE: _____ **Date:** _____

Gynecologic History

Please indicate if you have had one of the following

___ Hysterectomy ___ Incontinence surgery ___ Pelvic laparoscopy

___ Cystocele repair (bladder lift) ___ Rectocele repair ___ Urethral surgery

Have you gone through menopause Y___ N___ If so are you on hormonal replacement Y___ N___

Obstetric History

of pregnancies _____ # of vaginal deliveries _____ # of C-sections _____

UDI-6

Do you experience the following? If so how much are you bothered by:	NOT AT ALL	SLIGHTLY	MODERATELY	GREATLY
Frequent urination?	0	1	2	3
Urine leakage related to the feeling of urgency? (sudden desire to urinate)	0	1	2	3
Urine leakage related to physical activity, coughing, or sneezing?	0	1	2	3
Small amounts of urine leakage (drops)?	0	1	2	3
Difficulty emptying your bladder?	0	1	2	3
Pain or discomfort in the lower abdominal or genital area?	0	1	2	3

Score _____

IIQ-7

Over the past month has the leakage of urine and/or prolapsed affected:	NOT AT ALL	SLIGHTLY	MODERATELY	GREATLY
Your ability to do household chores (cooking, housecleaning)?	0	1	2	3
Your physical recreation such as walking, or other exercise?	0	1	2	3
Your ability to attend entertainment activities (movie, concerts)?	0	1	2	3
Your ability to travel by car more than 30 minutes from home?	0	1	2	3
Your participation in social activities outside your home?	0	1	2	3
Your emotional health (nervousness, depression, etc)?	0	1	2	3
Made you feel frustrated?	0	1	2	3

Score _____

If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? Circle the number that best reflects your feelings about your urinary problem.

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10

Pleased

Terrible