



Account # _____

PATIENT INFORMATION

First Name (legal)	Middle Initial	Last Name	Age	Date of Birth	Sex	Marital Status
Street Address, Apt #			Patients' Occupation			Full Time Student <input type="checkbox"/>
City & State			Patients' Employer			
Zip			Employer Address			
Phone Number			City & State			
Social Security Number			Zip			
In Case of Emergency (Friend or Relative who does not live with you)			Employer Phone Number			
Phone Number						
Spouse's Name		Cell Phone Number				

BILLING INFORMATION

Responsible Party (if same as above, skip to Insurance Information)	Phone Number	Relationship to the Patient <input type="checkbox"/> (1) Self <input type="checkbox"/> (2) Spouse <input type="checkbox"/> (3) Child <input type="checkbox"/> (4) Other
Street Address, Apt #	Responsible Party's Employer	
City & State	Employers' Phone Number	
Zip	Social Security Number	Date of Birth

PRIMARY OR MAIN INSURANCE

WORKERS' COMPENSATION (for work-related injury)

Company		Company	
Policy Holders' Name		Street Address	
Policy Number		City & State	
Group Number		Zip	
Policy Holders' Social Security Number	Policy Holders' Date of Birth	Contact Person & Phone Number	
Policy Holders' Employer Name	Claim Number	Date of Injury	
Phone Number	Employer at the time of injury		

MEDICARE SUPPLEMENT OR SECONDARY INSURANCE

THIRD INSURANCE

Company		Company	
Policy Holders' Name		Policy Holders' Name	
Policy Number	Group Number	Policy Number	Group Number
Policy Holders' Social Security Number	Policy Holders' Date of Birth	Policy Holders' Social Security Number	Policy Holders' Date of Birth
Policy Holders' Employer Name	Policy Holders' Employer Name		
Phone Number	Phone Number		

PATIENT REFERRED BY: DOCTOR RELATIVE FRIEND ADVERTISEMENT OTHER

NAME OF REFERRING DOCTOR _____

NAME OF FAMILY DOCTOR _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I hereby authorize examination and treatment deemed necessary by my physician. I, the undersigned, authorize and assign payment of medical benefits to which I am entitled to my physicians for any services furnished to me. I understand I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

PATIENT SIGNATURE: _____ DATE: _____

The Iowa Clinic, P.C. – Urology Division – New Patient Form

Name: _____ **Date of Birth** _____

Reason for seeing the physician today: _____

Referring Physician: _____

Please check the box for "Yes", if you are currently experiencing any of the following symptoms or diseases and check "No", if you are not.

SYMPTOM/DISEASE	YES	NO	COMMENTS
Have you had a fever?			
Had recent weight loss? How many pounds?			
Persistent feeling of being tired?			
Do you have problems with a dry mouth?			
Have you experienced any chest pain or discomfort?			
Do you have any difficulty breathing?			
Do you have problems with nausea or vomiting?			
Do you have difficulty with urination?			
Do you have back or flank pain?			
Do you have difficulty with erections?			
Do you have numbness or tingling? Where?			
Do you have any skin rashes?			
Do you have difficulty with "hot flashes"?			
Do you have difficulty with depression?			

Please list any surgeries you have had: _____

Please list any medical conditions you have:

High Blood Pressure Diabetes Heart Disease

Other: _____

-- PLEASE TURN OVER --

Please check yes if anyone in your immediate family has any of the following:

Disease	Yes	No	Family Member
High Blood Pressure			
Heart Disease			
Diabetes			
Kidney Cancer			
Kidney Stones			
Bladder Cancer			
Prostate Cancer			
Kidney Cancer			
Other _____			

Please Indicate Your Personal Use of the Following:

Social History	Yes	No	
Do you currently smoke?			Packs per Day _____
Have you ever smoked?			Quit _____ Packs Per Day _____
Do you drink alcohol?			Beverage _____ Drinks per Day _____
Do you drink caffeine?			Beverage _____ Drinks per Day _____

Please list all medications you are currently taking (prescription and over-the-counter):

Please list your allergies: _____

What pharmacy do you currently use? _____

INTERNATIONAL PROSTATE SYMPTOM SCORE (I-PSS)

Patient Name _____

Date of Birth _____

	<i>Not at all</i>	<i>Less than 1 time in 5</i>	<i>Less than half the time</i>	<i>About half the time</i>	<i>More than half the time</i>	<i>Almost always</i>	<i>Your score</i>
1. Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
	<i>None</i>	<i>1 time</i>	<i>2 times</i>	<i>3 times</i>	<i>4 times</i>	<i>5 times or more</i>	
7. Nocturia 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	
TOTAL I-PSS SCORE							
Quality of Life Due to Urinary Symptoms 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?							
	<i>Delighted</i>	<i>Pleased</i>	<i>Mostly satisfied</i>	<i>Mixed - About equally satisfied and dissatisfied</i>	<i>Mostly dissatisfied</i>	<i>Unhappy</i>	<i>Terrible</i>
	0	1	2	3	4	5	6

Above history reviewed with patient and amended as necessary

Patient Signature

Physician Signature

Date

Date

Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel.

The last 2 columns on the right are for your doctor to assess your score. Please do not mark anything in these columns. Be sure to bring this questionnaire with you into the examination room so that you can review your answers with your doctor.

Patient's name: _____ Today's date: _____

	0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1 How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2 a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
b. If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3 Are you currently sexually active? YES _____ NO _____							
4 a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5 Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6 Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7 a. If you have pain, is it usually...		Mild	Moderate	Severe			
b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8 a. If you have urgency, is it usually...		Mild	Moderate	Severe			
b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
SYMPTOM SCORE (1, 2a, 4a, 5, 6, 7a, 8a) – SUBTOTAL							
BOTHER SCORE (2b, 4b, 7b, 8b) – SUBTOTAL							
TOTAL SCORE (Symptom Score + Bother Score) =							



CONSENT TO RELEASE INFORMATION



Name: _____ Date of Birth: _____

I, the undersigned, hereby authorize The Iowa Clinic, P.C. to release medical information concerning the above named patient to the names listed below. (For minors, per Iowa State Law, information will be given to both parents unless ordered otherwise.)

Medical information includes, but is not limited to, identification of providers of care, diagnosis, procedures, demographic information (but not including psychotherapy notes).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This information relates to medical information and treatment only. We may contact you regarding any billing information. You may leave a message on my: Home answering machine: [] No [] Yes. My home number is: _____ Work answering machine: [] No [] Yes. My work number is: _____ Cell Phone [] No [] Yes. My cell number is: _____

I understand that I may revoke this consent at any time by sending a written notice to the office.

I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

I do not want information released regarding: _____* *If selecting this option, please complete the Request for Restrictions of Use & Disclosure of Protected Healthcare Information Form.

Signature of patient or legal guardian _____ Date _____ Address _____ City _____ State _____ Zip Code _____ Relationship (if not patient) _____

Please note: This authorization does not provide the above named person(s) with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner or personal health care representative or if you want to set up a living will, please discuss this with your primary care physician or your attorney.



THE IOWA CLINIC, P.C.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in The Iowa Clinic, P.C. Notice of Privacy Practices. The Iowa Clinic, P.C. is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing below, you are acknowledging that you have received a copy of The Iowa Clinic, P.C.'s Notice of Privacy Practices.

Patient name: _____

Patient Representative: _____

Relationship to Patient: _____

Signature: _____ Date: _____, 20__

THE IOWA CLINIC, P.C. USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement not obtained: _____

Signature: _____ Date: _____