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Dear ,

Thank you for entrusting RTR Urology with your care! We are looking forward to meeting you at your first visit! Please take a moment to look at our website: www.rtrurology.com so that you will be familiar with your provider.

Enclosed you will find your patient information forms. Please fill these out completely, and bring them with you to your appointment. We ask that you arrive 30 minutes early so that we can get all of your information entered into our electronic health record.

We would appreciate your assistance with your insurance policies:

1) Please bring your driver's license or another photo ID, along with all of your insurance cards so that we can scan them into your medical chart.
2) If you have an HMO policy, please check with your Primary Care Physician for the required authorization. We will need this faxed to our office 48 hours prior to your visit. Our fax number is (941) 485-7677. If you are unable to present an authorization, and you wish to be seen without it, you will be responsible for paying for your visit, in full, at the time of service.
3) Many people have commercial insurance coverage that have high deductibles, so we will also require payment at the time of service if you have not met your deductible.

If you need to reschedule your appointment, we would appreciate at least a 48 hour notification by calling (941) 485-3351 and then pressing zero.

Please remember to *arrive 30 minutes prior* to your appointment time, and please *be prepared to provide a urine sample.*

Thank you again for choosing RTR Urology for your urological care. We appreciate your assistance in order to ensure that your health record is correct, and things go smoothly every time you visit.

842 Sunset Lake Blvd., Bldg. B Suite 403, Venice, FL 34292
Office: (941) 485-3351 (24 Hour) • Fax: (941) 485-7677 • www.rtrurology.com

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name	Date of Birth	Medical Record Number
Address (Street, City, State, ZIP Code)		Telephone Number

I request that my health information or medical billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

Authorized Name	Relationship to Patient

*DO NOT discuss or provide information to the following individuals or entities:

Restricted Name/Entity	Relationship to Patient

*I request the use of ONLY the following address and/or phone number(s) to contact me regarding my health or billing information:

____

____

____

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that would violate the law. If we agree to the restriction, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient

____

THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

*Granted __________ Denied __________

*If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s).

Reason(s) for Denial, if Applicable ______________________________

____

____

Physician Office Representative: Date:

PATIENT HISTORY FORM

Today's Date______/______/______ Date of Last Physical Exam ______/______/______

Last Name____________________ First Name____________________ Middle__________

Social Security No.________________ Date of Birth______/______/______

CHIEF COMPLAINT / PRESENT ILLNESS

Please check appropriate box.

Kidney stones	[ ]	Urinary frequency	[ ]	Urinary incontinence	[ ]
Infection in kidneys, bladder or urine	[ ]	Urinary urgency	[ ]	Painful urination	[ ]
		Urinary retention	[ ]	Blood in urine	[ ]
Urinary hestiancy	[ ]	Prostatitis	[ ]	Impotence	[ ]

Is your urinary stream weak? [ ] Strong? [ ]

Do you get up at night to urinate? [ ] How many times? ________________

Please describe your problem in detail:

____

____

____

____

____

Location of the problem:____________________ How long does problem last?____________________

Onset of problem:____________________

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the severity of the problem

1 2 3 4 5 6 7 8 9 10

Does the problem interfere with normal functions? Y N

Physician use only:	# Answers	Level of Service
	1 - 3	1 or 2
	4+	3 - 5

Past Medical & Surgical History

ADDITIONAL ILLNESSES (Past/Present):

Heart disease	[ ]	High blood pressure	[ ]	Diabetes	[ ]
Emphysema	[ ]	Tuberculosis	[ ]	Cancer	[ ]

Other:____________________

Previous surgeries: Please list with dates

____

Medications with dosages and frequencies:

____

ALLERGIES: Iodine__________ Latex__________ Other__________

MEDICATION ALLERGIES:

____

FAMILY HISTORY:

Father: Age________ Deceased________ Cause of death________

Mother: Age________ Deceased________ Cause of death________

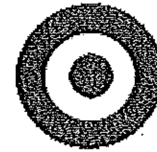
Siblings: Age________ Deceased________ Cause of death________

Children: How many?________ Illnesses?________

Family Illnesses: Heart Disease Diabetes Prostate Cancer Other________

____

International prostate symptom score (IPSS)



Name: Date:

	Not at all	Less than 1 time in 5	Less than half the	About half the time	More than half the	Almost always	**Your score**
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
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	
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	
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	

	None	1 time	2 times	3 times	4 times	5 times or more	**Your score**
Nocturia Over the past month, many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	

Total IPSS score	

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed – about equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Total score: 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.

24 HOUR VOIDING DIARY

Patient: ____________________ Chart #: __________ Date: __________

Time of Day	Amount Voided	Catheter Amount If you self Cath.	Did you Feel Empty?	Did you Feel the Urge to To go?	# of pads Used per Day	Additional Comments

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Directions to RTR Urology

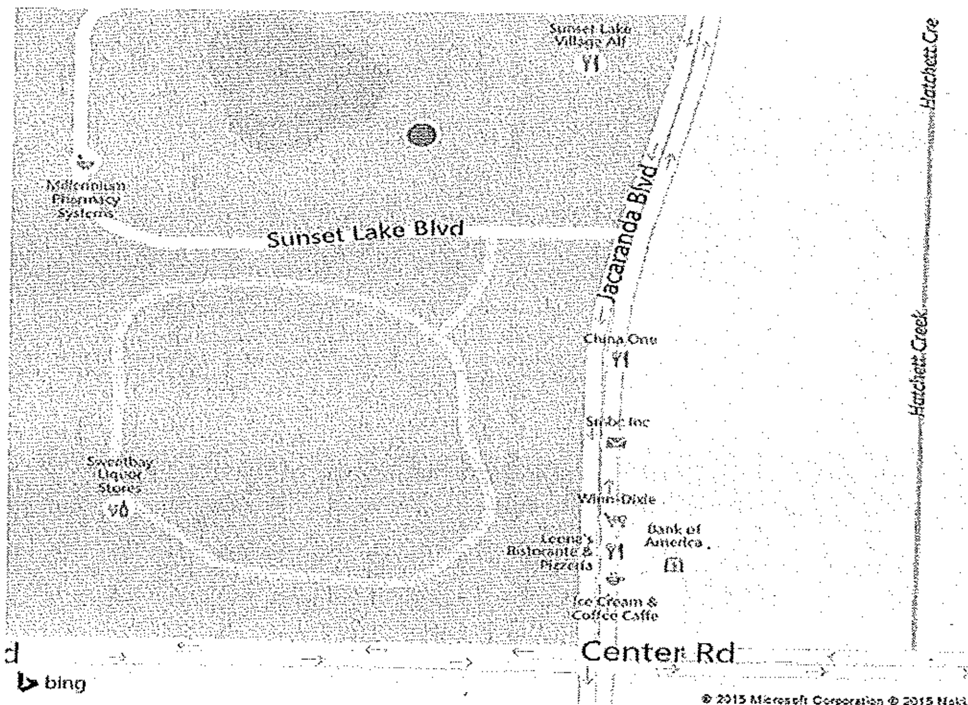
Lakeside Medical Center

From Route 41 North or South

- Take Center Rd east 2.3 miles to the intersection of Jacaranda Blvd
- Take a left onto Jacaranda Blvd
- Go .2 miles and take a left Sunset Lake Blvd
- Take a right into the first entrance for Lakeside Medical Center
- RTR Urology is located in # 842-B, on the right, Suite 403, 2nd floor

From I-75 North or South

- Take Exit 193, Jacaranda Blvd towards Vencie
- Go 2 Miles on Jacaranda and take a right on Sunset Lake Blvd
- Take a right into the first entrance for Lakeside Medical Center
- RTR Urology is located in # 842-B, on the right, Suite 403, 2nd Floor



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