

Pediatric Urology

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UrologyClinics
of North Texas



Dallas
Plano
Allen

Parents of _____:

We welcome you to our practice and look forward to seeing your child on:

Date:
Time:

Enclosed you will find registration forms which need to be completed prior to your appointment. In addition, below is a checklist to assist you and your family in preparing for your appointment.

Checklist for your first appointment:

- Bring your insurance card and present to the receptionist upon arrival.
- Please fax or mail your completed forms back to our office. These are entered into our database prior to your visit and will save time at your initial visit.
- IMPORTANT:** Bring any diagnostic reports and films related to your condition with you to the appointment. This will avoid repeating studies and will assist with your treatment plan. You will need to pick these up from the radiology department where they were performed.
- Please call our office prior to your appointment to verify we received necessary information. Without the information (records, films, etc.) we will have to reschedule your appointment.
- If you need language translation assistance, please bring an adult translator to your appointment.
- If you will be more than 10 minutes late for your appointment, please call our office to verify that your appointment can still be accommodated.
- If you are being seen for any bladder/wetting issues, please arrive with a full bladder.

PLEASE MAKE SURE ALL PAPERWORK AND DOCUMENTS ARE COMPLETE PRIOR TO YOUR VISIT.

If you have any questions contact our office at (214) 750-0808.

Office services are payable at the time of service. Payment can be made by Visa, MasterCard, Discover, American Express, cash or check.

NORTH TEXAS PEDIATRIC UROLOGY ASSOCIATES

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NORTH TEXAS PEDIATRIC UROLOGY ASSOCIATES

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New Patient or Consultation Encounter Form

Date: _____

Patient Name: _____ DOB: _____ Acct. #: _____

Child's Pediatrician Name: _____ and Fax #: _____

Reason for today's visit: _____

Race/Ethnicity: Caucasian African American Hispanic Other _____

Past Medical, Family & Social History: (Level 3 = 1 in 2 categories, Level 4 & 5 = 1 in 3 categories)

Past Medical History:

Prenatal history:

Full term Premature If premature, how many weeks? _____ Birth Weight _____

Prior illnesses and injuries: None

Prior surgeries and dates: None

Prior hospitalizations: None

Current Medications and doses: None

Drug Allergies: None

Other Allergies: None
(Example: Environmental, Food or Latex) _____

Family History:

List all serious illnesses and genitourinary problems in your immediate family and family member affected:
(Example: Kidney problems – stones, surgery, blood in urine; Bladder problems – UTIs, wetting or other issues; Undescended Testicles, Hypospadias, any problems with surgery or anesthesia, etc): None

Any Brothers? _____ Sisters? _____ Do they have any medical problems?

Social History:

Where does your child spend his/her day?: Home Daycare School/Grade _____

With whom does your child live? _____

SEE OTHER SIDE

If your child has Wetting, Urinary Infections or Reflux:

Please complete the following section.

Mark any that apply to the patient:

Bladder:

- Frequent urination
- Daytime accidents, # per day: _____
- Nighttime accidents, # per night: _____
- # of times child empties bladder per day: _____
- Holds or postpones going to bathroom
- Races to go to the bathroom
- Age when potty trained (daytime): _____
- Can't feel the need to urinate

Bowel:

- Constipation, if so, # of stools per week: _____
- Stool soiling
- Pain with stools
- Blood on stools
- Stool stops up toilet
- Diarrhea
- Frequent tummy aches

Review of Systems: (Level 3 = 1 pertinent, Level 4 = 2-9, Level 5 = 10+)

Do you now or have you had any problems in the past 3 months related to the following systems?

Please explain any Yes answers in space provided below:

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Glasses/Contacts	Y	N
Other _____		

Allergic/Immunologic

Eczema	Y	N
Dermatitis	Y	N
Allergies	Y	N
Other _____		

Neurological

Seizure Disorder	Y	N
Difficulty w balance and/or coordination	Y	N
Problems w memory	Y	N
Weakness or numbness	Y	N
Difficulty speaking or swallowing	Y	N

Endocrine

Diabetes	Y	N
Growth problems	Y	N
Other _____		

Gastrointestinal

Appetite changes	Y	N
Diarrhea	Y	N
Constipation	Y	N
Abdominal pain	Y	N
Nausea/Vomiting	Y	N
Other _____		

Cardiovascular

History of:		
Heart Murmur	Y	N
Heart Defect	Y	N
High blood pressure	Y	N
Palpitations	Y	N
Chest Pain	Y	N
Other _____		

Skin

Rashes or Eczema	Y	N
Lesions	Y	N
Scars	Y	N
Masses	Y	N
Other _____		

Musculoskeletal

Connective tissue disease	Y	N
Arthritis	Y	N
Special Needs: (i.e.: brace, wheelchair, other)	Y	N
Decreased Muscle Tone	Y	N
Assistance with Mobility	Y	N

Ear/Nose/Throat/Mouth

Difficulty hearing	Y	N
Recurrent bloody nose	Y	N
Hoarseness	Y	N
Difficulty swallowing	Y	N
Recent Nasal Discharge	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Blood in Urine	Y	N
Other _____		

Respiratory

History of Asthma, Wheezing or Reactive Airway Disease	Y	N
Shortness of breath	Y	N
History of RSV	Y	N
Cough	Y	N
Other _____		

Hematologic/Lymphatic

Unusual bleeding / bruising	Y	N
Anemia	Y	N
Lymph node pain or enlargement	Y	N
Other _____		

Psychologic

Developmental Issues	Y	N
Hyper or Hypo activity	Y	N
Depression	Y	N
Sleep Disturbances	Y	N
ADD/ADHD	Y	N
Other _____		

Explanation of any of the above items to which **Yes** was checked: _____

Are there any other problems not covered by the above list? _____

PATIENT REGISTRATION FORM

(Please print)

PATIENT NAME: (Last): _____ (First): _____ (MI): _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone (____) _____ Cell: (____) _____

Birth Date: ____/____/____ Sex: M__ F__

Referring Physician Name: _____ Phone: _____

GUARDIAN INFORMATION:

Name: _____ Relationship to Patient: _____

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___

Guardian SS#: _____

Occupation: _____ Work #: _____

Employer Name: _____

Address: _____

Spouse's Name: _____ Work phone (____) _____ Ext. _____

Emergency Contact: _____ Phone (____) _____ Pager: _____

PLEASE BRING INSURANCE CARD TO COPY

Insurance Co. _____

Policy Number _____ Group Number _____

Member Service 800 #/ Provider 800# _____

Medicaid ID # _____

POLICY HOLDERS INFORMATION (to be completed by parent who holds policy)

Name of insured: _____

(or person financially responsible if uninsured)

Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Employer Address: _____

Social Security #: _____ Driver's License: _____ DOB: ____/____/____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I hereby authorize Urology Clinics of North Texas to release any information necessary to process a claim for insurance benefits. I hereby authorized payment directly to the physician if the claim is approved.

SIGN HERE: _____

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Urology Clinics of North Texas – Pediatric Associates

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through: _____

- If you have out-of-network benefits we will be happy to give you a receipt so that you may file
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 60 days, we may expect payment from you.
- If by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
 - 1) This is a pre-existing illness that is not covered by your plan
 - 2) You have not met your full calendar deductible
 - 3) The type of medical services required is not covered by your plan
 - 4) The health plan was not in effect at the time of service
 - 5) You have other insurance which must be filed first

Although benefits may be verified at the time of service it is not a guarantee of payment on what was quoted. Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of the above reasons, you will then become responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our priority is to provide you with the best possible care. We are pleased to welcome you to our practice.

Sincerely,

Urology Clinics of North Texas

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier.

Patient/Parent Signature

Date

Patient Name - printed

POLICY ON MANAGED CARE INSURERS

In order to accommodate the needs and requests of our patients we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of all of the plans. Each one has a different stipulation regarding how often services may be rendered and, even more importantly, where those services may be performed.

Even within the same insurance company the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patient is our primary concern. We are more than willing to provide that care within your insurance guidelines if you let us know *EACH* time of service exactly what those guidelines are.

Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to *BILL YOU DIRECTLY FOR THOSE CHARGES*. Payment for those charges is then your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

☪ ☪ ☪ ☪ ☪ ☪ ☪ ☪ ☪ ☪ ☪ ☪ ☪ ☪ ☪ ☪

I have read and understand the office policy stated above and agree to accept responsibility as described.

Signature of Patient/Responsible Party

Date

WAIVER TO RELEASE MEDICAL INFORMATION BY ELECTRONIC SUBMISSION

I, _____ give my permission for Urology Clinics of North Texas to release my medical information by electronic submission**. I release them from all liability in the processing of this act.

** We have a satellite office and thus will enable us to fax your medical records to the doctor if he is there.

Patient or Parent's Signature

Date