Advanced Urological Care
Dr. James Simon, M.D.
2222 N. Nevada Ave. Ste 5005
Colorado Springs, Co 80907
Phone: 719-387-1535 Fax: 719-473-1760

New Patient Forms

Welcome to Advanced Urological Care. Enclosed you will find our new patient forms. We ask that you please bring these forms completed to your initial appointment.

Insurance

To assure that your appointment is billed correctly, please bring your insurance card with you. If you do not have your insurance card you will need to provide your member ID #, Group #, and a complete billing address. If you do not have this information you will be considered self-pay and will need to pay in full at the time of your visit.

Payment of Services

Your insurance card should list a specialist copay and the amount you are required to pay. If you have a deductible amount we will collect this at the time of your visit. We will then bill the visit to your insurance. Payment is expected at the time of service.

Referral Policy

If your insurance requires a referral to be seen by Dr. Simon, this will be your responsibility to make sure our office has received this prior to scheduling an appointment.

Cancellations, No Show or Late Appointment Policy

We will call and confirm your appointment one business day in advance. If your schedule changes, we request 24 hours' notice if you need to cancel or reschedule an appointment. If you do not call to cancel or do not show up for your appointment, we reserve the right to charge a $50.00 fee. This cannot be billed to your insurance and must be paid before you can reschedule another appointment.

Please be aware that it may be difficult to find close parking so allow adequate time to get into the office once you arrive. For your convenience there is Valet parking available at no charge.

Thank you for selecting Advanced Urological Care. We look forward to taking care of your urological needs. If you have any questions please call our office during office hours Monday-Friday between 8:00 am to 4:30 pm.

You will be asked to leave a urine specimen when you arrive at the office.

Patient Information

(PLEASE PRINT LEGIBLY)

Name _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State ___ Zip Code _____

Street Address (if different) _____ City _____ State _____

Zip Code _____ Email _____ SS# _____

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status ___S ___ M___ D___ W Spouse's Name _____

Employers Name and Address _____

Preferred Pharmacy/Location _____ Phone _____

Emergency Contact Name _____ Phone _____

Insurance Information

Primary _____ Secondary _____

ID Number _____ ID Number _____

Group Number _____ Group Number _____

Insured Name (if different than patient or if patient is a minor)

Name _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State ___ Zip Code _____

Relationship to Patient _____

Referral Management

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

How Did You Hear About Us? _____

I hereby authorize Advanced Urological Care to provide medical treatment services to me and/or my dependents, and to use my Personal Health Information to file a claim for service with my insurance company. In doing so, I assign to the physician all payments for medical services provided. I understand that I am responsible for any amount not covered by my insurance. I also understand that if I do not have insurance, I am responsible for all charges associated with my visit and that payment is due at the time of my visit.

Signature _____ Date _____

Patient Name _____ Date _____

MEDICAL HISTORY

(PLEASE PRINT LEGIBLY)

Surgical Procedures

Type of surgery Year Hospital Surgeon

_____
_____
_____
_____
_____

Current Medications & Dosage

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies & Reactions

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family History

Bedwetting ___ Yes ___ No Who? _____ Age at onset _____
Diabetes ___ Yes ___ No Who? _____ Age at onset _____
Kidney Stones ___ Yes ___ No Who? _____ Age at onset _____
Prostate Cancer ___ Yes ___ No Who? _____ Age at onset _____

Social History

Have you smoked tobacco products? ___ Yes ___ No Current User _____ Former User _____
How many years did, or have you smoked? _____
Do you use caffeine? ___ Yes ___ No If yes, how many cups per day? _____
Do you drink alcohol? ___ Yes ___ No If yes, describe use: _____ Mild _____ Moderate _____ Heavy
Travel Overseas? ___ Yes ___ No When _____ Where _____
Are you retired? ___ Yes ___ No ___ Semi
Occupation _____
Are your parents living? ___ Yes ___ No
If not, age and cause of death: Mother _____ Father _____

Women ONLY Health Section

Number of children _____
Are you on Birth Control? ___ Yes ___ No
Do you have painful Periods? ___ Yes ___ No
Number of Pregnancies _____
Do you have irregular Periods? ___ Yes ___ No
Are you sexually active? ___ Yes ___ No

Patient Name_____ Date_____

PAST MEDICAL HISTORY

Please check all that apply

	Onset date MM/YY		Onset date MM/YY
___ Abdominal Aortic Aneurysm	_____	___ DVT (blood clot in legs)	_____
___ Alcohol Withdrawal	_____	___ Dyspareunia (painful intercourse)	_____
___ Anemia	_____	___ Elevated Blood Pressure	_____
___ Angina Pectoris (chest pain)	_____	___ Elevated Prostate Specific Antigen	_____
___ Aortic Valve Disease	_____	___ Emphysema	_____
___ Aortic valve replacement	_____	___ Fibromyalgia	_____
___ Appendicitis	_____	___ Frequent UTIs	_____
___ Asthma	_____	___ Gastro Esophageal Reflux-GERD	_____
___ Backache	_____	___ Glaucoma	_____
___ Bladder Cancer	_____	___ Head Injury	_____
___ BPH (enlarged prostate)	_____	___ Heart Disease	_____
___ Breast Neoplasm, Malignant	_____	___ Heart Failure	_____
___ Bronchitis	_____	___ Hematuria (blood in urine)	_____
___ Cardiac Dysrhythmia(irregular heartbeat)	_____	___ Hepatitis	_____
___ Carotid Stenosis	_____	___ HIV/AIDS	_____
___ Cataracts	_____	___ Hormone Replacement Therapy	_____
___ Cervical Cancer	_____	___ Incontinence(leakage)	_____
___ Cesarean Delivery	_____	___ Infection of Kidney	_____
___ Cholelithiasis (gall stones)	_____	___ Kidney Stones	_____
___ Chronic Prostatitis	_____	___ Kidney X-ray (IVP)	_____
___ Chronic Renal Failure	_____	___ Mitral Valve Repair	_____
___ Coagulation Defect (bruise easily)	_____	___ Multiple Sclerosis	_____
___ Colitis, Ulcerative	_____	___ Myocardial Infraction (heart attack)	_____
___ Colon Cancer	_____	___ Neuropathy	_____
___ Congestive Heart Failure	_____	___ Nocturnal Enuresis	_____
___ COPD	_____	___ Parkinson's Disease	_____
___ Crohn's Disease	_____	___ Peripheral Vascular Disease	_____
___ CVA (stroke)	_____	___ Prostate Cancer	_____
___ Cystitis (bladder infections)	_____	___ Senile Dementia	_____
___ Cystocele	_____	___ Sleep Apnea	_____
___ Cystoscopy	_____	___ Testicular Cancer	_____
___ Diabetes Mellitus, Type I IDDM (insulin dependent)	_____	___ Urethral Stricture	_____
		___ Other	_____
___ Diabetes Mellitus, Type II	_____	___ Other	_____

Patient Name _____ Date _____

Reason for Visit

(PLEASE PRINT LEGIBLY)

Chief Complaint

What is the main reason for your visit today? _____

Have you ever seen a Urologist before? ___Yes ___ No If yes, who and When? _____

If male, have you had a PSA blood test? ___ Yes ___ No If yes, please list result and date _____

History of Present Illness

When did you first notice the problem? Date: (MM/YY) _____

Is the problem continuous or does it come and go? _____

Does anything make your problem worse or better? ___ Yes ___ No Which? ___ Worse ___ Better

Review of Systems

Do you currently have any problems listed below: (Please Check One)

Constitutional Symptoms	
Weight Loss	___ Yes ___ No
Fever	___ Yes ___ No
Chills	___ Yes ___ No
Other	___ Yes ___ No
Eyes	
Blurred Vision	___ Yes ___ No
Eye Pain	___ Yes ___ No
Other	___ Yes ___ No
Cardiovascular	
Chest Pain	___ Yes ___ No
Rapid Heartbeat	___ Yes ___ No
Other	___ Yes ___ No
Respiratory	
Shortness of Breath	___ Yes ___ No
Frequent Cough	___ Yes ___ No
Other	___ Yes ___ No
Gastrointestinal	
Constipation	___ Yes ___ No
Diarrhea	___ Yes ___ No
Abdominal Pain	___ Yes ___ No
Vomiting	___ Yes ___ No
Other	___ Yes ___ No

Genitourinary	
Blood in Urine	___ Yes ___ No
Urinary Frequency	___ Yes ___ No
Burning on Urination	___ Yes ___ No
Urinary Leakage	___ Yes ___ No
Bedwetting	___ Yes ___ No
Difficulty with Intercourse	___ Yes ___ No
Other	___ Yes ___ No
Neurological	
Tremors	___ Yes ___ No
Loss of Balance	___ Yes ___ No
Memory Loss	___ Yes ___ No
Other	___ Yes ___ No
Musculoskeletal	
Joint Pain	___ Yes ___ No
Bone Pain	___ Yes ___ No
Back Pain	___ Yes ___ No
Other	___ Yes ___ No
Endocrine	
Heat Intolerance	___ Yes ___ No
Cold Intolerance	___ Yes ___ No
Increased Thirst	___ Yes ___ No
Other	___ Yes ___ No
Hematologic	
Easily Bruised	___ Yes ___ No
Swollen Lymph Nodes	___ Yes ___ No
Easy Bleeding	___ Yes ___ No
Other	___ Yes ___ No

Bladder Symptom Questionnaire

Name: _____ Date: _____

Doctor: _____

Which symptoms best describe you? Select all that apply.

- ☐ Frequent urination—day, night, or both
- ☐ Sudden or strong urge to urinate
- ☐ Leakage with little or no warning—sometimes unable to make it to the bathroom in time
- ☐ Unable to completely empty bladder—feels like there is more even after going to the bathroom
- ☐ Accidental leakage with physical activity—exercising, sneezing, or coughing
- ☐ Bladder or pelvic pain
- ☐ Problems with bowel function (if checked, please select symptom below)
  - ☐ Accidental loss or leakage of stool ☐ Constipation ☐ Other
- ☐ No bladder or bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? _____

Have you tried medications to help your bladder symptoms? ☐ Yes ☐ No

If yes, how many different medications have you tried? _____

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select number.

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

No Relief ***Complete Symptom Relief***

Are you still taking any of these medications? ☐ Yes ☐ No

if no, why have you stopped taking them?

- ☐ Did not work as well as expected ☐ Side effects ☐ Expense
- ☐ Interaction with other medications ☐ Other

If Side effects or Other checked, please explain: _____

Behavior modifications tried? _____

(i.e, reduced fluid intake, caffeine reduction, Kegel exercises, physicial therapy, or lifestyle changes)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Select a number.

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

Not Frustrated ***Very Frustrated***

Are you interested in learning more about additional treatment alternatives to bladder medications?

☐ Yes ☐ No

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Signature _____ Date _____

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Protected health information (PHI) will be disclosed or used by Advanced Urological Care for the purposes of treatment, obtaining payment, or supporting day-to-day health care operations.

I understand that I have a right to request restrictions of the uses and disclosures of my PHI for the above stated purpose.

I understand I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

We may need to contact you regarding information pertaining to your treatment. If we are unable to reach you, it may be necessary to leave a message. Any message we leave may contain confidential information not intended for others. To avoid any breach in confidentiality, please review the choices below and check those that apply:

___ Yes, the doctor's office may email me.

___ Yes, the doctor's office may leave messages on my answering machine/voice mail.

___ No, do not leave messages. ___ I have no answering machine.

In some cases, it is helpful for a spouse, family member, or trusted friend to be informed of your medical care, to include test results. Pease mark yes or no below.

___ No, do not discuss my medical care with anyone other than myself.

___ Yes, your office may discuss my medical care with the following people:

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Signature of Patient/Guardian _____ Date _____