Urology Clinic P.C.

Jaime L. VanOveren D.O.
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Patient Information
(This information is necessary for our files and will be considered CONFIDENTIAL)

Last Name_____ First Name _____ Middle Name_____ Birth date ____/____/_____

Mailing Address_____ City _____ State _____ Zip _____

Phone (____)_____ Cell Phone (____)_____ Social Security #_____ Sex_____

Marital Status: **S** ☐ **M** ☐ **D** ☐ **W** ☐ Preferred Language **English** **Other** _____**Decline** ☐

Race _____**Decline** ☐ Ethnicity: **Hispanic** **Non-Hispanic** **Decline**☐

Preference for appointment reminders **Printed** **Electronic** **Phone** **Email address**_____

Family Physician_____Pharmacy_____Spouse's Name_____

Employer_____ Phone _____

Emergency Contact (not living with you) Name_____ Phone_____

RESPONSIBLE PERSON FOR ACCOUNT IF DIFFERENT THAN PATIENT

Name _____ Social Security # _____ Birth date_____

Address_____ City_____ State____ Zip_____ Phone(___)_____

INSURANCE INFORMATION IF DIFFERENT THAN PATIENT

IF YOU ARE NOT THE INSURED YOU ARE REQUIRED ** TO FILL OUT BELOW**

PRIMARY CARDHOLDER NAME_____ Birth date ____/____/_____

Relationship to Patient_____ SS#_____

FINANCIAL OBLIGATIONS

I have been given the opportunity to read and review Urology Clinic P.C.'s financial policy. I understand that I am responsible for payment in full of all charges incurred, including costs not covered by my insurance, I further understand I am responsible for contacting and/or following up with my insurance company should they not pay in a timely manner. Urology Clinic PC will charge a $50 fee for no show of appointments or canceling appointment less than 24 business hours before scheduled appointment.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been given the opportunity to read a copy of Urology Clinic P.C.'s Notice of Privacy Practices (HIPPA).

* _____ _____

Signature of Patient for HIPPA and FINANCIAL OBLIGATIONS (or guardian if minor) **DATE**

AUTHORIZATION TO SHARE YOUR MEDICAL INFORMATION

I authorize Urology Clinic P.C. to share medical information with my designated person (e.g. your partner, spouse, relative or friend.) You can appoint several persons if you want to, or leave it blank. If someone calls or comes in to ask for any information about you, the name of this person must be on this form, if not; we can not and will not give any information.

Urology Clinic P.C. can release my health information of billing to the following.

(NAME of person)_____**Relation**_____

(NAME of person)_____**Relation**_____

* _____ _____

Signature of Patient (or guardian if minor) **Date**

Today's Date _____/_____/_____

PATIENT HISTORY FORM

Name_____ Date of Birth _____/_____/_____

Chief Complaint (What is the main reason for your visit today? Please describe in Detail)

_____

_____

_____

Height ____ feet___inches Weight_____

MEDICAL HISTORY

Allergies:

- ☐ None Known
- ☐ Sulfa
- ☐ Penicillin
- ☐ Other Antibiotic or medication

  _____

  _____
- ☐ IVP/CAT Scan Contrast
- ☐ Latex
- ☐ Foods

  _____

  _____

Previous Medical Illnesses:

Have you ever had any of the following?

- ☐ Asthma
- ☐ Emphysema
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart attack or heart condition
- ☐ Increased blood pressure
- ☐ Blood Disorder
- ☐ Ulcer Disease
- ☐ Gallbladder disease
- ☐ Stroke
- ☐ Thyroid condition
- ☐ Kidney stones / disease
- ☐ Any other condition not listed
- ☐ None of the above

Have you ever been hospitalized?

If so, when, where, and for what reason

_____

_____

_____

Have you ever had any operation?

If so, please list (dates if known)

_____

_____

_____

Social History:

Current smoker ☐ Former smoker ☐ Never ☐

Packs per day? _____ Years smoked? _____

Do you use marijuana? If yes how much_____

Any illicit drug use? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If Yes, how much? _____

Family History:

Has anyone in your family had any of the following diseases

Relation to you

- ☐ Hypertension _____
- ☐ Hyperlipidemia _____
- ☐ Coronary heart disease: _____
- ☐ Diabetes _____
- ☐ COPD _____
- ☐ Thyroid disease _____
- ☐ Kidney disease _____
- ☐ Kidney Stones _____
- ☐ Prostate cancer _____
- ☐ Breast cancer _____
- ☐ Other cancer _____
- ☐ None of the above

For Women Only: Number of live births _____

Type of delivery:

Vaginal: _____ Cesarean: _____

When was your last pap smear? _____

For Men Only: Prostate Symptom Score

Over the past month or so, how often have you had the following:

(0)=Never, (3)=half the time, (5)=always.

1. Felt as if bladder not empty after voiding 0 1 2 3 4 5
2. Need to urinate again within 2 hours 0 1 2 3 4 5
3. Stopped and started again while urinating 0 1 2 3 4 5
4. Found it difficult to postpone urination 0 1 2 3 4 5
5. Had a weak urinary stream 0 1 2 3 4 5
6. Had to push or strain to begin urination 0 1 2 3 4 5
7. Number of times you get up at night to urinate 0 1 2 3 4 5

Date of last PSA_____

Value of last PSA _____

Total Symptom Score_____

Patient Name: _____

Review of Systems: Do you currently have any problems related to the following systems?

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Headache	Y	N
Other		
_____		
Eyes		
Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other		
_____		
Allergic/Immunologic		
Hay fever	Y	N
Drug allergies	Y	N
Other		
_____		
Neurological		
Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other		
_____		
Endocrine		
Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		
_____		
Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other		
_____		
Cardiovascular		
Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Integumentary		
Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other _____		
Musculoskeletal		
Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other _____		
Ear/Nose/Throat/Mouth		
Ear infections	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other _____		
Genitourinary		
Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		
Respiratory		
Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		
Hematologic / Lymphatic		
Swollen Glands	Y	N
Blood clotting problems	Y	N
Other _____		
Psychological		
Are you generally satisfied with life?	Y	N
Are you severely depressed?	Y	N
Have you ever considered suicide?	Y	N
Other _____		

Reviewed by: _____ **Date:** _____

Patient Name_____ DOB _____

Medication

Revised 10/17/16

Urology Clinic P.C.

JAMIE VANOVEREN, D.O.
CLAY M. PENDLETON, M.D.

We are excited to announce the arrival of our new patient portal.

What does that mean?

Test results in real time (no need to wait for the mail)	**Ability to view parts of your medical chart**
Quicker communication with your subspecialist	**Request appointments**
Verify appointments	**Your link is to your "chart" and is secure**
Send a message to our nurse or front office	**Billing questions**
It's there to assist you in managing your care	**Check your appointment dates and times**

Our physicians would like all patients to have this capability. All communications are encrypted and HIPAA compliant.

You will be prompted to change your password on your first entrance into the website. Please make this a unique password that contains **UPPER, lower case letters** as well as at **least one number** and a **special character**.

Your User Name: First letter of your first name and your entire last name. The first two are caps. (ie. JDoe)

We used **Password! and last 4 digits of your Social Security number** as your first password. This meets the criteria for a password, but you can't use it. You must come up with something new, and will be prompted to do so. **If you forget your password, please call our office at (970) 871-9710. In order for your account to be activated you need to send a message to one of our staff member.**

Staff

Steamboat: Wendy (nurse questions), Leena (front desk appointments) 970-871-9710
Craig & Meeker: Angela (nurse questions), Sammi (front desk/ appointments) 970-871-9710
Frisco: Dianne (nurse questions), Erica (front desk appointments) 970-368-6247
Granby and Kremmling: Dianne (nurse questions), Erica (front desk appointments) 970-368-6247
Billing questions Alicia or Shelly 970-871-9710

Visit our web page at http://www.urologyclinicpc.com/
Click on the Patient Portal or go to
https://webview.emds.com/ucpc

What we need from you: **Question you will need to answer:**

Print Your Name: _____

Your Email address: _____

Security Question: _____

Security Answer: _____

Last four of your Social Security Number: _____
If minor child please give last four of responsible party

Name of responsible party _____

Please don't forget to email our staff through the portal to activate your account. Thank you.