

**Beaver
Valley
Urology**
Please Print

PATIENT INFORMATION

Patient Name _____ Patient Birthdate ____/____/____
Address _____ Patient Sex (circle) M F
_____ Martial Status (circle) S M D W
_____ Social Security # ____-____-____
Home Phone # _____ Cell Phone # _____
Employer Name _____ Employer Phone # _____
Employer Address _____

INSURANCE INFORMATION (Must Be Completed)

1. Name of PRIMARY Insurance Company _____ Claim Mailing Address _____ _____ _____ Phone # _____ Owner of Policy _____ Date of Birth _____ Phone # _____ Address _____ <input type="checkbox"/> Check Here if Patient is Owner Relationship _____ ID/Policy # _____ Group # _____ Employer _____ *Name of Primary Care Physician _____	2. Name of SECONDARY Insurance Company _____ Claim Mailing Address _____ _____ _____ Phone # _____ Subscriber Name _____ Subscriber Date of Birth _____ Subscriber Phone # _____ Subscriber Address _____ _____ Relationship _____ ID/Policy # _____ Group # _____ Employer _____ Name of Primary Care Physician _____
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OTHER INFORMATION

Spouse Name _____ *Name of Referring Doctor _____
Spouse's Employer _____ Phone # _____
Phone # _____
In Case of Emergency Contact (not at same address)
Name _____
Phone _____
PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

Beaver Valley Urology, LTD

Patient Name: _____ Date of Birth: _____

Assignment and Release

Authorization for release of information

I authorize the release of any medical information to my insurance carriers concerning my medical treatment necessary to process my claim to Beaver Valley Urology, LTD. I understand that any false claims, statements of documents or concealment of material fact may be prosecuted under applicable federal and state law.

AUTHORIZATION FOR ASSIGNMENT FO PAYMENTS

I authorize the payment of medical benefits to Beaver Valley Urology, LTD for all services rendered to me. ***I UNDERSTAND THAT I AM REPOSNSIBLE FOR ALL CHARGES INCLUDING CO-PAYMENTS AND/OR CHARGES THAT ARE NOT COVERED BY MY INSURANCE. I UNDERSTAND THAT REFERRALS FOR PARTICIPANTS ARE THE PARTICIPANT'S RESPONSIBILITY. IF NO AUTHORIZATION WAS APPROVED PRIOR TO SERVICES, I WILL ACCEPT FINANCIAL RESPONSIBILITY FOR THE SERVICES RENDERED. THIS PAYMENT WILL BE DUE AT THE TIME OF SERVICE OR WHEN DEMANDED.***

If I have liability for my medical services such as auto, worker's compensation, accident, etc, ***I UNDERSTAND THAT IA M ULTIMATELY LIABLE FOR SERVICES RENDERED TO ME AND I AGGREE TO PAY DIRECTLY TO BEAVER VALLEY UROLOGY SHOULD THE CLAIM WITH MY INSURANCE CARRIER AND/OR POLICY HOLDER BE DENIED OR CHALLENGED.***

CONSENT TO TREATMENT

I authorize treatment to myself by Beaver Valley Urology, LTD including the employees therein.

(Signature of patient or authorized person/guardian)

(date)

Patient History Form

Today's Date _____ Date Of Birth _____

Last Name _____ First Name _____ M _____

What is the main reason for your visit today? _____

Past Medical History:

List all medical conditions current and prior (ex. high blood pressure, heart disease, diabetes, etc.)

Past Surgical History:

List all surgical procedures that you have had done in your lifetime.

Social History:

Do you smoke? Y N Have you previously? _____

Do you drink alcoholic beverages? Y N _____

Do you drink caffeine? Y N _____

Family History:

List any remarkable medical history (ex. heart disease, diabetes, cancer)

Mother _____ Maternal Grandmother _____

Paternal Grandmother _____

Father _____ Paternal Grandfather _____

Maternal Grandfather _____

Brother _____

Sister _____

Allergies:

List any allergies to medications _____

Current medications:

List all medications including over the counter drugs and vitamins _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

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
 Other _____

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 infection 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 problem Y N
 Other _____

Psychologic

Are you generally satisfied with your life? Y N
 Do you feel severely depressed? Y N
 Have you considered suicide? Y N
 Other _____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____

Date: ____ / ____ / ____

Could your urinary symptoms be caused by BPH?

Answer these simple questions and share them with your doctor.

American Urological Association (AUA) Symptom Index for BPH

1. INCOMPLETE EMPTYING

Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

2. FREQUENCY

During the last month, how often have you had to urinate again less than 2 hours after you finished urinating?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

3. INTERMITTENCY

During the last month, how often have you stopped and started again several times when you urinated?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

4. URGENCY

During the last month, how often have you found it difficult to postpone urination?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

5. WEAK STREAM

During the last month, how often have you had a weak urinary stream?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

6. STRAINING

During the last month, how often have you had to push or strain to begin urination?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
0	1	2	3	4	5

7. NOCTURIA

During the last 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?

Never	1 time a night	2 times a night	3 times a night	4 times a night	5 times or more a night
0	1	2	3	4	5

Now add up your Symptom Score (1-7 Mild, 8-19 Moderate, 20-35 Severe):

Name and date:

Adapted from American Urological Association. *Guideline on the Management of Benign Prostatic Hyperplasia (BPH)*. Linthicum, Md: American Urological Association Education and Research, Inc; 2003:1-22,1-23,3-51.

The Disease Specific Quality of Life Question

The International Prostate Symptom Score uses the same 7 questions as the AUA Symptom Index (presented above) with the addition of the following Disease Specific Quality of Life Question (bother score) scored on a scale from 0 to 6 points (delighted to terrible).

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?

Delighted	Pleased	Mostly satisfied	Mixed	Mostly disappointed	Unhappy	Terrible
①	②	③	④	⑤	⑥	

Only your doctor can tell if your symptoms are due to BPH and not another condition such as prostate cancer. Common side effects of FLOMAX are runny nose, dizziness and decrease in semen. A sudden decrease in blood pressure may occur upon standing, rarely resulting in fainting. So when starting FLOMAX, avoid situations where injury could result.

Please see Patient Information and full Prescribing Information on last pages of pad.

FLOMAX[®]
TAMSULOSIN HCl CAPSULES 0.4 MG

GO WITH THE FLO