ADVANCED UROLOGY

1555 & 1557 Janmar Road, Snellville, GA 30078
10730 Medlock Bridge Road, Johns Creek, GA 30097
2711 Irvin Way, Decatur, GA 30030
501 Crown Pointe Way, Lawrenceville, GA 30046
Phone (678) 344-8900 Fax (678) 666-5201
Email: info@urologygeorgia.com

Georgia's *Best* Urologists

Jitesh Patel, M.D.

Mukesh Patel, M.D.

Tariq Hakky, M.D.

Vishal Bhalani, M.D.

Derek Prabharasuth, M.D.

A. Dev Mally, M.D.

Neal Patel, M.D.

T. Casey McCullough, D.O.

Naveen Arora, M.D.

Karl Pete, M.D.

Himanshu Aggarwal, M.D.

Our mission is to better the lives of those we touch. Our foundation is exceptional service, personalized care, and cutting-edge treatments. We work hard to continuously improve our accessibility, service, and quality. We strive to build lifelong relationships with our patients and referring providers.

Thank you for choosing Advanced Urology for your urologic needs.

In order to help make your upcoming office visit as easy as possible, we have enclosed necessary forms which should be completed **prior** to your arrival. We recommend that you personally deliver, fax, e-mail, or mail the forms back to us.

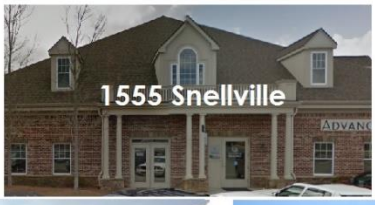
Please also bring:

- **Insurance Cards**
- **Photo Identification**
- **Form of payment** (we accept cash, debit card, MasterCard, Visa & American Express) No checks. *Need help with your high deductible? We also take Care Credit & Parasail.*
- A list of all the medications you are currently taking
- Any medical records, blood lab work, **diagnostic testing** in actual film format or on CD (**CD is preferred**) that you may have done as it pertains to your visit. Feel free to drop these off at the office prior to your visit.

If you are bringing records in-person, **please give all of the records to the check-in staff upon arrival and do not hold on to these records**. We will electronically scan these documents and return them to you. Following these instructions will greatly facilitate your visit.

We very much value our patients' time and will work to minimize your wait in our office. In order to ensure thorough evaluation, please refrain from emptying your bladder right before your visit, as we will likely need a urine sample from you.

Our hours of operation, map to our office, and other useful information are available on our website at www.urologygeorgia.com. If you have any questions or need to verify the location, please call our friendly staff.



We look forward to meeting you soon, and thank you for choosing us for your urologic care!

Sincerely,
The Advanced Urology Team

ADVANCED UROLOGY ADVANCED UROLOGY SURGERY CENTER ADVANCED UROLOGY SURGERY CENTER Atlanta Center for Urinary Control UROLOGY SURGERY CENTER JOHNS CREEK

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Patient Information

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status: _____

Social Security: _____ Race: _____

Preferred Language: _____ Ethnicity: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

In the event of an emergency, who would you like us to contact?

Name: _____ Phone Number: _____

Relationship To Patient: _____ Secondary Phone Number: _____

Physician Information (Please list primary doctor to send communication)

Primary Care Physician's Name: _____ Phone Number: _____

Primary Care Physician's Address: _____

Referring Doctor's Name: _____ Phone Number: _____

Referring Doctor's Address: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

To the best of my knowledge, all of this is true and complete. I understand that I am responsible to pay for all services rendered to me, I grant permission to my physician to mutually exchange medical information with referring physician and/or associates. I hereby authorize disclosure of my medical records to my insurance carrier to obtain reimbursement.

Signature: _____ Date: _____

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Authorization for the Release of Protected Health Information

Patient Name: _____

Date of Birth:_____ Phone: _____

I authorize representatives from Advanced Urology to release or obtain the health information as directed below:

Self (Patient)

Obtain from / Release to:

Facility: _____

Address: _____

Phone Number: _____

Fax Number: _____

Release to/Obtain from:

Advanced Urology
1555 & 1557 Janmar Road, Snellville, GA 30078
10730 Medlock Bridge Road, Johns Creek, GA 30097
2711 Irvin Way, Decatur, GA 30030

Phone: 678.344.8900 Fax: 678.666.5201

This request applies to:

- All healthcare information.
- Healthcare information relating to the following treatment, condition, or dates:

  _____
- Other: _____

Signature:_____ Date: _____

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Authorization To Release Medical Information

Patient Name: _____

Date of Birth:_____ Phone: _____

I authorize Advanced Urology to release my medical information to another person(s)/family member(s).
(This is separate from Emergency Contact and also does not include Doctors,
see previous page for Medical Release)

Yes or No (If Yes) Name: _____

Relationship: _____ Phone Number: _____

Yes or No (If Yes) Name: _____

Relationship: _____ Phone Number: _____

Yes or No (If Yes) Name: _____

Relationship: _____ Phone Number: _____

Signature:_____ Date: _____

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Payment Policy

Thank you for choosing Advanced Urology as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your account is turned over to a Collection Agency, a $100 collections processing fee will be added to any outstanding balance.

3. Non-covered services. Please be aware that some of the services you receive may be non- covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

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6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines.

For additional information or questions about this policy please contact:

Advanced Urology Business Office Monday – Friday 8am-5pm 678.344.8900 ext. 802

Signature of patient or responsible party **Date**

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Name:_____ Date of Birth: _____

Doctor that referred you to Advanced Urology: _____

Do you have a cardiologist? **YES** **NO** If yes, please list their name: _____

Cardiologist Phone: _____ If known, please list the date of last appointment: _____

What is the reason for your visit today? _____

Do you live in an assisted living facility? **YES** **NO** Name of Facility: _____

Address of Facility: _____

Please list any medication allergies:	Reaction to Medication:
_____	_____
_____	_____
_____	_____
_____	_____

Other Allergies: _____

Do you take any medications? **YES** **NO**

Please list all medication(s) including dosage (prescription, over-the-counter, and herbal): _____

_____

_____

_____

_____

Please list all significant medical history: _____

_____

_____

_____

_____

Please list all prior surgeries including the year: _____

_____

_____

_____

Name:_____ Date of Birth: _____

WOMEN: Please complete the following:

Number of Pregnancies: _____ Number of Cesarean Sections: _____

Number of Vaginal Deliveries: _____ Are You Currently Pregnant? **YES** **NO**

Do you take prescription blood thinners? **YES** **NO**

Do you take aspirin or anti-inflammatory medicines every day? **YES** **NO**

Have you had a heart valve replacement? **YES** **NO**

Have you had a joint replacement? **YES** **NO**

Are you allergic to latex? **YES** **NO**

Are you allergic to intravenous contrast (dye)? **YES** **NO**

Social History

Current Marital Status: S M W D

Occupation: _____

Do you use tobacco products: **YES** **NO**

Do you drink alcohol: **YES** **NO**

Type:_____

Beer Wine Liquor

Packs/day:_____

Daily Weekly Monthly Socially Rarely

How many Years? _____

Amount: _____

Tried to quit? _____

Last Drink: _____

Years since quitting? _____

Passive smoke exposure? _____

Do you have an Advance Directive: **YES** **NO**

Do you have a family history of any of the following: (**Circle all that apply**)

Blood Disease
BPH (Prostate Enlargement)
Seizure Disorder
Thyroid Disorder
Urinary Tract Infections
Migraines
Eczema
Diabetes
Coronary Artery Disease
Hyperlipidemia
Inflammatory Bowel Disease
Renal Failure
Urolithiasis (Urinary Tract Stones)
Hypertension (High Blood Pressure)
Cerebrovascular (Stroke)
Cancer: Type 1. _____
2. _____
Which Family Member 1. _____
2. _____

Other: _____

_____

Name:_____ Date of Birth: _____

Review of Systems

Constitutional

Change in Appetite	YES	NO
Chills	YES	NO
Fatigue	YES	NO
Fever	YES	NO

Eyes

Blurred vision	YES	NO
Changes in vision	YES	NO

ENT

Headaches	YES	NO
Nasal congestion	YES	NO
Runny Nose	YES	NO
Sinus pain	YES	NO
Sore throat	YES	NO

Breast

Additional symptoms	YES	NO
Lumps	YES	NO
Nipple discharge	YES	NO
Swelling	YES	NO
Tenderness	YES	NO

Cardiovascular

Cardiac murmurs	YES	NO
Chest pains	YES	NO
Irregular heartbeat	YES	NO

Respiratory

Painful respiration	YES	NO
Shortness of breath	YES	NO
Wheezing	YES	NO

Gastrointestinal

Abdominal Pain	YES	NO
Blood in Stool	YES	NO
Diarrhea	YES	NO
Loss of appetite	YES	NO
Nausea	YES	NO
Vomiting	YES	NO

Allergic-Immunologic

Allergic Dermatitis	YES	NO
Frequent Illness	YES	NO
Sinus Allergy Symptom	YES	NO

Genito-Urinary

Decreased sex drive	YES	NO
Decreased stream	YES	NO
Difficulty voiding	YES	NO
Dysmenorrhea (painful periods)	YES	NO
Dysuria (painful urination)	YES	NO
Frequency of urination	YES	NO
Impotence	YES	NO
Incontinence	YES	NO
Nocturia (frequent urination at night)	YES	NO
Post void dribbling	YES	NO
Retention	YES	NO
Scrotal pain	YES	NO
Urgency	YES	NO
Vaginal discharge	YES	NO

Neurological

Headaches	YES	NO
Incoordination	YES	NO
Numbness or tingling sensation	YES	NO
Seizures	YES	NO

Musculoskeletal

Back pain	YES	NO
Bone pain	YES	NO
Joint pain	YES	NO
Muscle pain	YES	NO

Endocrine

Cold intolerance	YES	NO
Excessive thirst	YES	NO
Excessive urination	YES	NO
Heat intolerance	YES	NO
Weight gain	YES	NO
Weight loss	YES	NO

Hematology/Lymphatic

Easy bleeding	YES	NO
Easy bruising	YES	NO
Lymph enlargement	YES	NO

ADVANCED UROLOGY

BLADDER SURVEY

Name: _____ DOB: _____

Date Completed: _____

Frequency

How frequently do you urinate? *

- Every Hour or less
- Every 1 - 2 Hours
- Every 3 - 4 Hours
- Every 5 - 6 Hours
- I do not go to the bathroom frequently

How much are you bothered by frequent urination? *

- Not at all
- Slightly
- Moderately
- Greatly

How long have you had symptoms of frequent urination? *

- Symptoms for Less than 1 year
- Symptoms for the last year
- Symptoms for the last 2 years
- Symptoms for the last 3-5 years
- Symptoms for over the last 5 years

Nocturia

How often do you get up at night to urinate? *

- Every hour or less
- Every 1-2 hours
- Every 3-4 hours
- Every 5-6 hours
- I do not get up at night to urinate

How long have you had symptoms of night time urination? *

- I do not get up at night to urinate
- Symptoms for less than 1 year
- Symptoms for the last year
- Symptoms for the last 2 years
- Symptoms for the last 3-5 years
- Symptoms for over the last 5 years

Urgency

Do you ever have the sudden or constant urge to urinate that is uncomfortable? *

- Yes, I feel the urge to urinate that is strong and or uncomfortable
- No, I don't have any significant urgency with my urination

How often have you felt, sudden or constant, strong uncomfortable urges to urinate? *

- I do not feel uncomfortable urges to urinate
- Symptoms for 6 months or less
- Symptoms for 6 months to 1 year
- Symptoms for the last 2 years
- Symptoms for over the last 5 years

Difficulty Emptying

Do you have difficulty emptying or the feeling of incomplete emptying of your bladder? *

- Yes, I have difficulty emptying my bladder
- No, I do not have any difficulty emptying my bladder

How long have you had the feeling of difficulty or incomplete emptying of your urine? *

- I do not have any difficulty emptying my urine
- Symptoms for 6 months or less
- Symptoms for 6 months to 1 year
- Symptoms for the last 2 years
- Symptoms for over the last 5 years

How much are you bothered by difficulty emptying your bladder? *

- Not at all
- Slightly
- Moderately
- Greatly

ADVANCED UROLOGY

BLADDER SURVEY

Name: _____ DOB: _____

Date Completed: _____

Stress Incontinence

Do you leak urine accidentally when you cough, sneeze, laugh, or exercise? *

- Yes
- No

How long have you had leakage of urine when you cough, sneeze, laugh, or exercise? *

- I do not have leakage of urine when I cough, sneeze, laugh, or exercise
- Symptoms for 6 months or less
- Symptoms for 6 months to 1 year
- Symptoms for the last 2 years
- Symptoms for over the last 5 years

How much are you bothered by urine leakage related to physical activity, coughing, or sneezing? *

- Not at all
- Slightly
- Moderately
- Greatly

Urge Incontinence

Do you leak urine accidentally when you develop the urge to urinate but cannot make it to the restroom in time? *

- Yes
- No

How long have you had leakage of urine feel the urge? *

- I do not have urine leakage when I feel the urge
- Symptoms for 6 months or less
- Symptoms for 6 months to 1 year
- Symptoms for the last 2 years
- Symptoms for over the last 5 years

How much are you bothered by urine leakage related to feeling of urgency? *

- Not at all
- Slightly
- Moderately
- Greatly

Incontinence Impact

Has urine leakage affected your ability to do household chores? *

- Not at all
- Slightly
- Moderately
- Greatly

Has urine leakage affected your participation in social activities? *

- Not at all
- Slightly
- Moderately
- Greatly

Has urine leakage affected your physical recreation? *

- Not at all
- Slightly
- Moderately
- Greatly

Has urine leakage affected your emotional health? *

- Not at all
- Slightly
- Moderately
- Greatly

Has urine leakage affected your entertainment activities? *

- Not at all
- Slightly
- Moderately
- Greatly

Has urine leakage caused you to feel frustrated? *

- Not at all
- Slightly
- Moderately
- Greatly

Has urine leakage affected your ability to travel by car or bus more than 30 minutes from home? *

- Not at all
- Slightly
- Moderately
- Greatly

ADVANCED UROLOGY

BLADDER SURVEY

Name: _____ DOB: _____

Date Completed: _____

Pelvic Pain

Do you have pelvic pain? *

- Yes
- No

How much are you bothered by pelvic pain? *

- Not at all
- Slightly
- Moderately
- Greatly

Pad Usage

Do you use pads or diapers for urinary leakage? *

- Yes
- No

Pad usage *

- 1-2 pads per day
- 1-4 pads per day
- 4-6 pads per day
- >6 pads per day

Medications

Have you been prescribed medication(s) to treat over active bladder? *

- Yes
- No
- I do not know

Did you experience any side effects while on the medication(s)? *

- Yes
- No

Please select any medications you have tried or are currently taking below: *

- Detrol LA
- Ditropan XL
- Elavil
- Elmiron
- Enablex
- Cardura
- Flomax
- Myrbetriq
- Oxytrol Patch
- Vesicare

Please select any side effect that applied to you *

- Unable to Urinate
- Difficulty Emptying My Bladder
- Dry Eyes
- Dry Mouth
- Constipation
- I have Glaucoma
- Other

Other Therapies

Have you tried lifestyle changes such as diet, exercise, and stress reduction? *

- Yes
- No

Have you tried bladder training? (following a fixed voiding schedule, whether or not you feel the urge to urinate) *

- Yes
- No

Have you tried pelvic floor muscle physical therapy? *

- Yes
- No
- I don't know