SAINT LUKE'S HEALTH SYSTEM PATIENT REGISTRATION SHEET

(Please Print)

Please present your insurance card(s) to the receptionist so we may obtain a copy for billing purposes.

Today's Date: _____ / _____ / _____ **MRN:** _____

PATIENT LAST NAME: _____ FIRST NAME: _____ MI: ____ SSN: _____

NICK NAME: _____ DATE OF BIRTH: ____ / ____ / ____ SEX: MALE / FEMALE

PHONE: _____ CELL: _____ WORK: _____

ETHNIC GROUP: HISPANIC /BLACK /WHITE /OTHER (SPECIFY) _____ RELIGION: _____

MARTIAL STATUS: _____ EDUCATION: _____ LANGUAGE: _____

EMAIL ADRESS: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ EMPLOYER PHONE: _____ FULL OR PART TIME (circle)

EMERGENCY CONTACT NAME: _____ ADDRESS: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ REFERRING PHYSICIAN PHONE: _____ FAX: _____

PRIMARY CARE PHYSICIAN: _____ PRIMARY PHYSICIAN PHONE: _____ FAX: _____

PREFERRED PHARMACY: _____ PHARMACY PHONE: _____

PHARMACY ADDRESS: _____

- - INSURANCE INFORMATION - -

PRIMARY INSURANCE: _____ GROUP NAME / #: _____ SUBSCRIBER DOB: _____

CERTIFICATE #: _____ SUBSCRIBER NAME: _____

SECONDARY INSURANCE: _____ GROUP NAME / #: _____ SUBSCRIBER DOB: _____

CERTIFICATE #: _____ SUBSCRIBER NAME: _____

- - SPECIAL PERMISSIONS - -

PLEASE INITIAL AND DATE APPLICABLE STATEMENTS BELOW:	INITIAL	DATE
I GIVE PERMISSION TO LEAVE VOICE MAIL OR ANSWERING MACHINE MESSAGES AT MY HOME. THE MESSAGE CAN INCLUDE THE NATURE OF THE CALL, BUT NOT SPECIFIC INFORMATION.		
I GIVE PERMISSION TO CALL ME ON MY CELL PHONE.		
I GIVE PERMISSION TO DISCUSS MY MEDICAL AND DENTAL CARE AND BILLING INFORMATION WITH (Another Individual (s)) _____ AND _____.		
I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES.		
I PREFER TO RECEIVE SAINT LUKE'S HEALTH SYSTEM INFORMATIONAL MAILINGS (circle one) YES NO		

I HAVE REVIEWED THE ABOVE INFORMATION AND, TO THE BEST OF MY KNOWLEDGE, IT IS CORRECT AND COMPLETE.

_____

(SIGNATURE OF PATIENT OR GUARDIAN) **DATE**

ALLERGIES:

(Medications / Anesthesia / Dyes / Tape / Iodine / Latex / Betadine / Food / Other)

Item	Type of Reaction	Item	Type of Reaction

CURRENT MEDICATIONS

(List all prescriptions and over the counter medications, i.e., vitamins, diet aids, herbs, laxatives, inhalers)

NONE ☐

Current Medication	Dose	Schedule	Last Taken	Current Medication	Dose	Schedule	Last Taken

Please list any prior surgeries:

_____

_____

_____

_____

BLADDER SATISFACTION SURVEY

Name_____ Doctor _____

Which symptoms best describe you?

Frequent Urination – Day, Night, or Both

Sudden or Strong Urge to urinate

Leaking with Urge or No Warning
(Unable to make it to the bathroom in time)

Leaking with Sneezing, Coughing, Exercising

Unable to Empty the Bladder

None of These Describe me

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? Yes No

If yes, check the medications you have tried:

Detrol® LA Ditropan XL® Flomax® Cardura®

Oxytrol® Patch Enablex® VESIcare® DDAVP®

Sanctura® Elavil® Elmiron® Other

Did these medications help your symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Completely Cured***

If you've stopped taking your meds explain why:
Did not Help Side Effects Too Expensive

Describe Side Effects

Behavior Modifications Tried_____
(i.e., caffeine intake, lifestyle changes, bladder training, pelvic floor muscle training)

What is your level of frustration with your bladder symptoms? Circle #

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated **Very Frustrated**

Do you currently have any problems with bowel function?:
Fecal Incontinence Constipation Other

I am interested in learning more about treatment alternatives to medications:
Yes No

Saint Luke's Urogynecology Center for Women

CHECKLIST: Review of Systems

General-

☐ Weight Loss or gain ☐ Fever or Chills ☐ Trouble Sleeping
☐ Fatigue ☐ Weakness

Skin-

☐ Rashes ☐ Itching ☐ Dryness
☐ Hair and nail changes

Head-

☐ Headache ☐ Head injury

Ears-

☐ Decreased hearing ☐ Earache
☐ Ringing in ears (tinnitus) ☐ Drainage

Eyes-

☐ Vision changes ☐ Blurry or double vision ☐ Cataracts
☐ Glasses or contacts ☐ Glaucoma

Nose-

☐ Stuffiness ☐ Itching ☐ Nosebleeds
☐ Discharge ☐ Hay fever ☐ Sinus pain

Breasts-

☐ Lumps ☐ Discharge
☐ Pain ☐ Self-exams

Respiratory-

☐ Cough (dry or wet, productive ☐ Coughing up blood (hemoptysis)
☐ Wheezing ☐ Shortness of breath (dyspnea)

Cardiovascular-

☐ Chest pain or discomfort ☐ Difficulty breathing lying down (orthopnea)
☐ Palpitations ☐ Swelling (edema)
☐ Shortness of breath with activity (dyspnea)

Gastrointestinal-

☐ Heartburn ☐ Rectal bleeding ☐ Constipation
☐ Nausea ☐ Diarrhea

Urinary-

☐ Frequency ☐ Blood in urine (hematuria)
☐ Urgency ☐ Burning or pain ☐ Incontinence

Genital-

☐ Pain with sex ☐ Hot Flashes ☐ Itching or rash
☐ Vaginal dryness ☐ Vaginal discharge ☐ STD's

Vascular-

☐ Calf pain with walking (Claudication) ☐ Leg cramping

Musculoskeletal-

☐ Muscle or joint pain ☐ Back pain ☐ Swelling of joints

Neurologic-

☐ Dizziness ☐ Weakness ☐ Tremor
☐ Fainting ☐ Numbness ☐ Seizures
☐ Tingling

Hemotolgic-

☐ Ease of bruising ☐ Ease of bleeding

Endocrine-

☐ Head or cold intolerance ☐ Frequent urination (polyuria)
☐ Change in appetite (polyphagia) ☐ Thirst (polydypsia)

Psychiatric-

☐ Nervousness ☐ Memory Loss ☐ Stress
☐ Depression

Bladder Health Questionnaire

Please bring this form with you on the day of your appointment

Question	Yes	No
How often do you urinate during the day / evening?		
How often do you get up at night to urinate?		
When did your bladder problems begin?		
Do you usually have a strong sense of urgency to urinate?		
Do you experience pain when your bladder if full?		
Can you postpone emptying your bladder easily?		
Do you lose urine when you are lying down or asleep?		
Do you lose urine when you sneeze, cough, jump, run or laugh?		
Do you lose urine when you get up from a sitting position?		
Do you lose urine when you hear, see or feel running water?		
Do you lose urine when you can't get to the bathroom on time?		
Do you lose urine when you don't even know it?		
Do you wear protection for urinary leakage?		
If yes, do you use panty liners shield type pads, briefs underwear?		
If yes, how many do you wear per day?		
Do you have difficulty starting your urine stream?		
How do you start your urine stream? ☐ Easy ☐ Push Strain ☐ wait less than 1 minute. ☐ wait more than 1 minute		
Do you have pain when emptying your bladder?		
When urinating, can you stop your stream?		
Do you feel you have completely emptied your bladder?		
Do you notice dribbling of urine after emptying your bladder?		
Have you ever had a tube placed in your bladder because you were unable to empty your bladder?		
Have you ever had your urethra dilated or stretched?		

Revised 2011

Bladder Health Questionnaire

Please bring this form with you on the day of your appointment

Question	Yes	No
Have you ever passed blood in your urine?		
Have you ever had a kidney or bladder stone?		
Have you been treated for 3 or more urinary tract infections?		
Have you had an infection within the last 6 months?		
Do you leak gas or stool?		
Are you constipated?		
If you are a female, how many pregnancies have you had? _____Vaginal deliveries _____C-Sections _____Miscarriages		
What treatments for your bladder problems have you tried in the past? ☐ Kegel Exercises ☐ Pessary Insertion ☐ Fluid/Diet Changes ☐ Collagen Injections		

Bladder Diary

This diary is a chart for you to report the amount you drink and the amount you drink and the amount you urinate (empty your bladder). Please complete this form for any 48-hour period prior to your appointment. Use a 2-cup measuring cup (or any other devise) to measure your urine. It can be washed in the dishwasher or discarded. Record the amount and type of fluids you drink and the amount of leakage if you leak urine.

Please bring this form with you on the day of your appointment.

Name: _____

Date	Time	Amount Urinated	Amount of Leakage: D-Drops M-Medium S-Soaked	Activity Only When You Leak	Amount of Fluid Intake and Type of Fluid

Revised 2011

Consent Forms

Saint Luke's Health System

Protected Health Information – Communication Preferences

Please communicate preferences about my health care with me in the following manner: (Check all that apply.)

- ☐ My home telephone number is:_____
  - ☐ Ok to leave a message with detailed information
  - ☐ Ok to leave a message with call-back information only
- ☐ My work telephone number is:_____
  - ☐ Ok to leave a message with detailed information
  - ☐ Ok to leave a message with call-back information only
- ☐ My cellular telephone number is:_____
  - ☐ Ok to leave a message with detailed information
  - ☐ Ok to leave a message with call-back information only
- ☐ Written communication
  - ☐ Ok to mail to my home address: _____
  - ☐ Ok to mail to my work/office: _____
- ☐ MySaintLuke's patient portal

Check applicable box:
☐ I was offered and made available, but I am electing not to receive a copy of SLHS Notice of Privacy Practices.
☐ I acknowledge receiving a copy of SLHS Notice of Privacy Practices.

You may discuss detailed information about my healthcare needs with the following individual(s):

Name of individual	Telephone number	Relationship to patient
1._____	_____	_____
2._____	_____	_____

Patient name:_____ Birthdate:_____ Patient Account #:_____

You will be asked to review and update your preferences on a yearly basis. You may change your preferences or withdraw permission for the individuals indicated above at any time by contacting your Saint Luke's provider. Your communication preferences applies to all providers and facilities within Saint Luke's Health System.

Note: These preferences do not apply to behavioral health visits.

_____/_____/_____
Signature of patient or personal representative* Date Time

*If signed by a personal representative, the following information must also be included:
Name of personal representative and description of their authority to act on behalf of patient: _____

Patient Label:

Clinic PHI Form

Saint Luke's Health System

Assignment of Benefit Release

I hereby assign to Saint Luke's Health System (SLHS) my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to SLHS. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan or government plan covering services provided by SLHS.

I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature:_____Date:_____Time:_____
(Signature of Patient or Parent, Legal Guardian or Representative)

AUTHORIZATION TO RELEASE INFORMATION FOR TREATMENT, BILLING, OR HEALTH CARE OPERATIONS

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that SLHS reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Records may be needed in order to process a claim for medical services. I authorize SLHS to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or any part of my medical record for the purpose of my treatment, billing, or pertinent health care operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.

Patient's Printed Name:_____

Patient's Date of Birth:_____

Minor Patient: ☐ Yes ☐ No

Signature:_____Date:_____Time:_____
(Patient or Legal Representative Signature)

Signature:_____Date:_____Time:_____
(Witness)

Patient Label:

SYS-829 (Rev. 05/22/18)