COMPREHENSIVE
UROLOGIC CARE

PATIENT INFORMATION (Please Print) Date: _____

First Name:_____ Middle Initial: _____ Last Name:_____

Birthdate: ___/____/_____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: (_____) _____

Secondary Phone: (_____) _____

Email Address: (Please print and avoid using work email)

Email :_____

☐ Male ☐ Female Social Security Number: _____-_____-_____ **(Required for Online Chart Access)**

Referring Physician: _____Primary Care Physician: _____

Employer: _____City, State, Zip Code: _____

Emergency Contact: _____Phone :( ) _____ Relationship:_____

PRIMARY INSURANCE PLAN NAME: _____

Please indicate: ☐ PPO ☐ HMO ☐ Medicare ☐ Self Insured

Insured Name on card If other than Patient: _____ Birthdate: ____/____/_____

Relationship to Patient: _____

SECONDARY INSURANCE PLAN NAME: _____

Please indicate: ☐ PPO ☐ HMO ☐ Medicare ☐ Self Insured

Insured Name on card If other than Patient: _____ Birthdate: ____/____/_____

Relationship to Patient: _____

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Patient First _____ Last_____Date of Birth: __/___/_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that I have been made aware of CUC's Notice of Privacy Practices, which is posted on their website, as well as available upon request in their office.

☐ **I Place No Restrictions**

☐ **Restrict all of my Protected Health Information, except for the following individuals:**

Name: _____Relationship:_____Date of Birth: _____

Name: _____Relationship:_____Date of Birth: _____

NOTICE OF INSURANCE RELEASE OF INFORMATION AND AUTHORIZATION FOR PAYMENT

- I authorize the release of any medical or other information acquired in the course of my examination or treatment to insurance carriers.
- I authorize payment of medical benefits direct to Comprehensive Urologic Care for medical/surgical services rendered to me or my dependents.
- I understand that it is my responsibility to satisfy any payment obligations required by my insurance carrier at the time of service and am financially responsible for any services not covered by my insurance carrier.

ACKNOWLEDGEMENT OF OFFICE POLICIES

I acknowledge that I have been made aware of CUC's Office Policies, which is posted on their website, as well as available upon request in their office.

Signature of Patient or Legal Guardian

X_____ Date:_____

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Patient Portal FAQ

What is the Patient Portal?

Our patient portal is a safe, secure website that allows patients to access certain parts of their medical records, appointment reminders, review demographic information, prescriptions and pharmacy information for accuracy.

What are the benefits to our patients?

You have quick, easy access to important parts of your medical chart. You can see, print and download this information at your convenience, without having to call the office.

Is the Patient Portal safe?

Absolutely. We've invested in a secure server and a secure web domain (denoted by the "s" in the https:// portion of our Patient Portal's URL) to ensure the safety and confidentiality of your medical records.

How do I sign up?

Just make sure we have your email address on file. After each visit, or any time a new document is added to your chart, you will receive an email notification. Just click the link that will take you to our Portal Homepage and you can sign in there.

I'm a first time user, how do I log on?

On the homepage, on the right hand side about midway down, the words "New User – Sign Up Now" appear in blue. Click on it and it that will take you through a 3-Step process to create your user name and password. Your CUC Chart ID User name can be unique or you can use your email address. Be sure your password has an upper case, number and special character (we recommend using an exclamation point).

Can I use the portal to schedule appointments?

It is not possible at this time to schedule appointments via the portal. Please call us during normal business hours at (847)382-5080 to schedule.

What if I forget my password?

On the homepage below the login box, there appears a "Forgot Password" link . Once you verify your account information, a new password will be sent to you via email.

What if I can't view my documents?

If you cannot open documents in the Visit Notes, Labs, or Reminders section of you chart, it is most likely because you do not have Adobe Reader installed. You can download this program for free from the internet.

Is the portal meant to replace an office visit?

Not at all. The portal is a communication tool between you and our office.

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Name:_____ **Date of Birth:**_____ **M** ☐ **F** ☐ **Today's Date:**_____

Primary Care MD:_____ **Referring MD:**_____

Pharmacy Name:_____ **Pharmacy Address:**_____

Past Medical History (Check any illnesses and tell us when they occurred).

Check this box if unknown or none apply ☐

Condition		Date	Condition		Date
Anemia	☐	_____	Heart Attack (MI)	☐	_____
Arthritis	☐	_____	Hepatitis	☐	_____
Asthma	☐	_____	Hypertension (High Blood Pressure)	☐	_____
Atrial Fibrillation	☐	_____	Hypothyroidism	☐	_____
Breast Cancer (Female)	☐	_____	Irritable Bowel Syndrome	☐	_____
Coronary Artery Disease	☐	_____	Migraines	☐	_____
COPD	☐	_____	High Cholesterol	☐	_____
Chest Pains (Angina)	☐	_____	Osteoporosis	☐	_____
Crohn's Disease	☐	_____	Paraplegia	☐	_____
Depression	☐	_____	Quadriplegia	☐	_____
Diabetes	☐	_____	Seizures	☐	_____
Diverticulosis	☐	_____	Spine Problems/Pain	☐	_____
Gout	☐	_____	Stroke/CVA	☐	_____
GERD	☐				

Other Information_____

Past Surgery (Check past surgeries and tell us when they occurred).

Check this box if unknown or none apply ☐

Condition		Date	Condition		Date
Amputation	☐	_____	Kidney/Ureter Stone (Basketing)	☐	_____
Angioplasty	☐	_____	Kidney/Ureter Stone (ESWL)	☐	_____
Appendectomy	☐	_____	Nephrectomy	☐	_____
AV Fistula	☐	_____	Orthopedic Surgery	☐	_____
Back Surgery	☐	_____	Peripheral Bypass Surgery	☐	_____
Cardiac Bypass	☐	_____	Prostate Surgery (Greenlight Laser) (male)	☐	_____
Colon Resection	☐	_____	Prostate Surgery (Microwave) (male)	☐	_____
Gall Bladder Removal	☐	_____	Prostate Surgery (TUNA) (male)	☐	_____
Gastric Bypass	☐	_____	Prostate Surgery (TURP) (male)	☐	_____
Hernia Repair	☐	_____	Radiation of Prostate (male)	☐	_____
Hysterectomy (Female)	☐	_____	Radical Prostatectomy (male)	☐	_____
Mesh Hernia Repair	☐	_____	Small Bowel Resection	☐	_____

Other Information_____

Past Urologic History (Check any illnesses and tell us when they occurred).

Check this box if unknown or none apply ☐

Condition		Date	Condition		Date
Bladder Cancer	☐	_____	Prostate Cancer (male)	☐	_____
Enlarged Prostate (BPH) (male)	☐	_____	Prostatitis (male)	☐	_____
Impotence (male)	☐	_____	Renal Insufficiency / Failure	☐	_____
Kidney Cancer	☐	_____	Urinary Incontinence	☐	_____
Kidney Cyst	☐	_____	Urinary Tract Infections (UTI)	☐	_____
Kidney Stones	☐	_____	Vasectomy (male)	☐	_____

Other Information_____

Family History: Check Box(es) for any illnesses in your immediate family.

Check this box if unknown or none apply ☐

Condition	Father	Mother	Brother	Sister	Family
Asthma	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Enlarged Prostate	☐		☐		☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Prostate Cancer	☐		☐		☐

Other Information_____

Social History

Do you smoke? Yes ☐ No ☐ How many packs/day?_____

Past Smoking? Yes ☐ No ☐

Do you Drink? Yes ☐ No ☐ How much?_____

Past Drinking? Yes ☐ No ☐ (Socially / Occasionally / Heavily / Recovering Alcoholic)

Living at? Home _____ Illicit drug use? Yes ☐ No ☐

Other Information_____

Current Medications (Please list all medications and dosage).

Check this box if unknown or none apply ☐

Medicines	Strength	Dosage	Duration	Notes
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____ _____ _____ _____ _____

Do you currently have any problems related to the following? Check applicable box if yes.

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight Loss

Gastrointestinal
- ☐ Abdominal
- ☐ Nausea/Vomiting
- ☐ Indigestion/Heartburn
- ☐ Loss of Appetite

Neurological
- ☐ Tremors
- ☐ Dizzy Spells
- ☐ Memory Problems
- ☐ Seizures

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Glaucoma

Endocrine
- ☐ Excessive Thirst
- ☐ Hot/Cold Intolerance
- ☐ Hot Flashes

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Irritable

Ear/Nose/Throat/Mouth
- ☐ Ear Infection
- ☐ Sore Throat
- ☐ Sinus Problems

Integumentary
- ☐ Skin Rash
- ☐ Boils
- ☐ Persistent Itch

Genitourinary
- ☐ Incontinence
- ☐ Painful Urination
- ☐ Frequent Urination

Cardiovascular
- ☐ Chest Pain
- ☐ Varicose Veins
- ☐ Palpitations/High BP

Hematologic/Lymphatic
- ☐ Abnormal Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Anemia

Reproductive (Male)
- ☐ Erection Problems
- ☐ Ejaculation Problems
- ☐ Infertility

Respiratory
- ☐ Wheezing
- ☐ Frequent Cough
- ☐ Shortness of Breath

Musculoskeletal
- ☐ Joint Pain
- ☐ Neck/Back Pain
- ☐ Bone Pain

Reproductive (Female)
- ☐ Menopause
- ☐ Vaginal Deliveries #_____
- ☐ Irregular Periods

Notes/Other:_____

_____

_____

Known Allergies? None Known ☐

- ☐ Penicillin (eg. Pen VK, Amoxicillin, Augmentin)
- ☐ Sulfa (eg. Septra, Bactrim)
- ☐ Cephalosporins (eg. Keflex, Duricef, Ceftin, Ceclor)
- ☐ Macrobid (Nitrofurantoin)
- ☐ Cipro
- ☐ Levaquin
- ☐ Tetracycline
- ☐ Latex
- ☐ Peanuts
- ☐ Shell Fish
- ☐ Iodine
- ☐ Demerol
- ☐ Morphine
- ☐ Codeine

Any Other:_____