I CAME HERE TODAY TO SEE DR. ______________________

DATE: ____________________ MRN: ____________

PATIENT INFORMATION (PLEASE PRINT PATIENT'S COMPLETE LEGAL NAME) Social Security Number: ______________

PATIENT: Last ______________________ First ______________ Middle ______________

Sex: M / F Birth Sex: M / F Date of Birth: ______________ Primary Language: ______________

Race: Black/African American Asian White American Indian / Alaskan Native Native Hawaiian / Pacific Islander Other Decline

Ethnicity: Hispanic / Latino Non-Hispanic / Non-Latino Unknown

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Street Address: ______________________ APT/UNIT#: ____________

City: ______________________ State ________ ZIP: ____________

Primary Phone # (INCLUDE AREA CODE) (____) ______________ Secondary phone # : (____) ______________

NORTHERN ADDRESS:

Street Address: ______________________

City/State/Zip: ______________________ Phone # : (____) ______________

Additional Information:

Email Address: ______________________ Would you like access to NCH Patient Portal? Y / N

Referring Physician: ______________ Local Primary Care Physician: ______________

Pharmacy: ______________ Phone # and/or Location: ______________

PATIENT/GUARANTOR EMPLOYER:

Name of Employer: ______________________

Employer Street Address: ______________________

Employer City/State/Zip: ______________________ Phone # : (____) ______________

Employment Status ☐ FT ☐ PT ☐ Retired ☐ Self ☐ Unemployed

EMERGENCY CONTACT INFORMATION:

Name: ______________ Relationship: ______________ Phone: (____) ______________

INSURANCE INFORMATION

Relationship of patient to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: ______________

If not *self*: Subscriber's Name: ______________________ Gender: ☐ Male ☐ Female

Subscriber's Social Security Number: ______________ Subscriber's Date of Birth: ______________

Address of Subscriber (if different from patient): ______________________

City/State/Zip: ______________________ Phone # : (____) ______________

I hereby acknowledge and/or agree to the following:

1) I hereby authorize this provider to treat me or my child and attest that the personal and financial information given above is true and that no information has been falsified.
2) I hereby authorize NCHMD, INC to contact me using my email address if I supply it on this form
3) A parent or guardian responsible for payment of the bill is accompanying the child at the time of service unless a separate permission form has been signed. NCHMD, INC cannot be bound by any divorce or other family relationship contracts.
4) I hereby authorize insurance benefits, including Medicare benefits, to be paid directly to the physician providing services and recognize it is my responsibility to pay for all non-covered services. I also authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid (CMS) and its agents, any other third party liability or insurance carrier, any information needed to determine these benefits or the benefits payable for related services.
5) I authorize NCHMD, INC to apply any funds received under this assignment which exceed the amount necessary to pay my charges to any unpaid NCHMD, INC bills of myself or an immediate family member.
6) I have reviewed and understand all the information on the back of this document, including HIPAA Notice of Privacy Practices Statement, as indicated with my signature and date below.
7) That the pathologists who may provide services to me are NOT agents or employees of the NCH Physician Group but are independent practitioners; that the NCH Physician Group delegates to the pathologists the provision of physician professional services to me, which operates to discharge the NCH Physician Group from any contractual obligations to provide said services to me; that the NCH Physician Group is not legally or vicariously responsible for the conduct or actions of the pathologists that may provide services to me.
8) That the undersigned does hereby release the NCH Physician Group, its agents, employees, officers and directors, from liability for all acts of the aforesaid physicians, negligent or otherwise.

Signature ______________________ Date ______________

NCH HEALTHCARE GROUP
(NCHHG)

PATIENT CONSENT FOR ALTERNATE COMMUNICATION OF PROTECTED HEALTH INFORMATION

I hereby give my consent for NCHHG to use and disclose my protected health information (PHI) in an alternate way so to expedite my treatment, payment and healthcare operations. I understand that NCHHG does not, in its normal course of business, use these alternate means of communication unless specifically instructed by the patient to do so. I have indicated by checking the appropriate boxes below that I have authorized NCHHG to contact me in alternate ways that are, by their design, not guaranteed to be secure. I will hold my physician and all of NCHHG harmless if, while employing one of these alternate means of communication, the information is inappropriately used by or disclosed to an individual or individuals not authorized by me to have this information. I also assume responsibility for the security of all information that is sent by me to my physician using any alternate communications listed below.

With my consent, NCH Healthcare Group

- ☐ Fax health information to my home # ____________________
- ☐ Fax health information to my work # ____________________
- ☐ Leave detailed messages on my voicemail at home # __________
- ☐ Leave detailed messages on my voicemail at work # __________
- ☐ Call my cell phone and leave detailed messages # __________
- ☐ Email me using secure email at ____________________
- ☐ Leave detailed messages with a family member/caregiver: Name(s)

  ____

  ____

I understand that I may revoke my consent for the use of alternate communications in writing using the revocation notice of this form, except to the extent that the practice has already made disclosures in reliance upon my prior consent.

______________________________ ______________

Signature of Patient or Legal Guardian — Patient Date of Birth

______________________________ ______________

Print Patient Name — Today's Date

Revised 4/21/2011

The IIEF-5 Questionnaire (SHIM)

Please encircle the response that best describes you for the following five questions:

Over the past 6 months:					
1. How do you rate your confidence that you could get and keep an erection?	Very low 1	Low 2	Moderate 3	High 4	Very high 5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Almost never of never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult 2	Difficult 3	Slightly difficult 4	Not difficult 5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5

Total Score: ____________________

1-7: Severe ED   8-11: Moderate ED   12-16: Mild-moderate ED   17-21: Mild ED   22-25: No ED

International Prostate Symptom Score (IPSS)

Patient Name: ______ **Today's Date:** ______

Daytime Phone Number: ______ **Date of Birth:** ______

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – 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?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = ______

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms

Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	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?	0	1	2	3	4	5	6

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)

1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you like to discuss a minimally invasive procedure to treat your bothersome urinary symptoms with your doctor?	Yes	No

The information provided in this form may be de-identified and aggregated and provided to a 3rd party for use.

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NCH UROLOGY

AMS Questionnaire

Which of the following symptoms apply to you at this time? Please, mark the appropriate box for each symptom. For symptoms that do not apply, please mark "none".

Symptoms:	**none**	**mild**	**moderate**	**severe**	**extremely severe**
Score =	**1**	**2**	**3**	**4**	**5**
1. **Decline in your feeling of general well-being** (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2. **Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3. **Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4. **Sleep problems** (difficulty in falling asleep, difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5. **Increased need for sleep, often feeling tired**	☐	☐	☐	☐	☐
6. **Irritability** (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7. **Nervousness** (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. **Anxiety** (feeling panicky)	☐	☐	☐	☐	☐
9. **Physical exhaustion / lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10. **Decrease in muscular strength** (feeling of weakness)	☐	☐	☐	☐	☐
11. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12. **Feeling that you have passed your peak**	☐	☐	☐	☐	☐
13. **Feeling burnt out, having hit rock-bottom**	☐	☐	☐	☐	☐
14. **Decrease in beard growth**	☐	☐	☐	☐	☐
15. **Decrease in ability/frequency to perform sexually**	☐	☐	☐	☐	☐
16. **Decrease in the number of morning erections**	☐	☐	☐	☐	☐
17. **Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Have you got any other major symptoms? Yes......... ☐ No.......... ☐

If Yes, please describe: ______________________________

____

THANK YOU VERY MUCH FOR YOUR COOPERATION