James E. Moyer, MD, FACS
Michael A. Eufemio, Jr. MD, FACS

422 Normal Street
East Stroudsburg, PA 18301
570-424-2100

100 Community Court, Suite 209
Tobyhanna, PA 18466
570-895-1087

Welcome to our office.

You are completing this new patient packet because you currently have a doctor's appointment scheduled in the near future.

It is important that you **arrive *30 minutes prior to your appointment time** so we can work with you to update your chart and get you into your appointment on time. If for any reason you will not make it to your appointment or will not be on time, please let us know as soon as possible. **BRING YOUR PHOTO ID AND INSURANCE CARDS** or you may not be seen.

Please fill out the enclosed paperwork (6 pages) prior to your visit and bring it with you when you come for your appointment. You may also mail it to us prior to your appointment at the address below or fax it to us at 570-421-7407.

Urology Associates of the Poconos
422 Normal Street
East Stroudsburg, PA 18301

Thank you in advance for your cooperation. Our first priority will always be your health and well being.

With Warm Regards,
Dr. Moyer, Dr. Eufemio, and staff

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Registration Form:

Name: (Last) (First) MI: SSN: _____-_____-_____

Mailing Address: City: State: Zip:

Circle primary phone to call Home Phone: __________________ Cell Phone: _____________________

Email Address: ____

Birth date: Sex: Age:

Employer: ____

Business Address: ____ Business Ph.________________________

Emergency Contact Name: ____Phone:____________________________________

Referring Doctor: _______________________________ Family Doctor: ___________________________________

PRIMARY INSURANCE

Person Responsible for Account: Last Name__________________________________ First Name_____________________________________

Relation to Patient____ Birth date___________________ Soc. Sec. #:______-______-______

Address (if different from patient's) ____ Phone_______________________________

City: _______________________________________ State: ______________ Zip: ___________

Person Responsible Employed by:____ Occupation: ____________________________________

Business Address: ____Business Ph:____________________________

Insurance Co: ____Subscriber#_______________________Phone:_________________________

ADDITIONAL INSURANCE? Yes_____ No_____

Person Responsible for Account: Last Name__________________________________ First Name__________________________MI__________

Relation to Patient____________________________________ Birth date________________ Soc. Sec. #:______-______-______

Address (if different from patient's) ____ Phone_____________________________________

City: _______________________________ State: ______________ Zip:___________

Person Responsible Employed by____ Occupation: ___________________________________

Business Address: ____Business Ph.____________________________

Insurance Co. ____Subscriber#_______________________Phone_________________________

CURRENT MEDICATIONS – Please list ALL medications you are currently taking including over the counter meds. Attach list if necessary.

Drug Name:	Strength:	Directions/How you take it:
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____

Local Pharmacy Name: ____ **Location:** ________________________________

Secondary Pharmacy Name: ____ **Location:** ________________________________

ALLERGIES – **Please list ALL types including SEASONAL , PET DANDER, and FOODS**

____

____

SOCIAL HISTORY (please circle one)

Marital Status:
Married Single Divorced Widowed Legally Separated Annulled Life Partner

Smokeless Tobacco Use: Yes No

Tobacco per day: None Yes (#______Packs/day ______Cigarettes/day) **If you previously stopped, When?** ________________

How many caffeinated drinks do you have each day? 0 1 2 3 4+

Do you drink alcohol? Yes (how many a day________________) Not Anymore Never Drank

Do you use Recreational Drugs? Yes (list what kind_____________________________________) No

Race:______________________________ **Ethnic Group**: _____________________________ **Preferred Language**_____________________________
* Sorry for the inconvenience. Race, Language, and Ethnicity are requirements from the government.

Have you had a blood transfusion? Yes No

Occupation:____

REVIEW OF SYSTEMS

Please CIRCLE if you CURRENTLY have any of the following diseases or conditions

Constitutional:	fever	weight loss	weight gain	night sweats	loss of energy
Ears, Nose, Mouth, Throat:	blurry vision	cataracts	blind		
Cardiovascular:	swelling	chest pain	irregular heartbeat		
Respiratory:	shortness of breath	wheezing	cough		
Gastrointestinal:	abdominal pain	nausea/vomiting		change in bowels	
Genitourinary:	pelvic pain	incontinence	frequency	retention	blood in urine
Musculoskeletal:	sore muscles	back pain	arthritis		
Skin:	rash	dry skin	bruising	lesions/ulcers	
Neurological:	dizziness	forgetfulness	loss of balance	depression	
Hematologic/Lymphatic:	swollen glands	bleeds easily	blood clots		

PATIENT'S HEIGHT: ___________ PATIENT'S WEIGHT: _________

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular
Atrial Fibrillation
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Heart Attack
Hypertension

Endocrine/Metabolic
Diabetes Mellitus,
non-insulin dependent
Diabetes Mellitus,
insulin dependent
Gout
Hyperthyroidism- increase
Hypothyroidism- decreased

General
Hepatitis A
Hepatitis B
Hepatitis C
High Cholesterol

GI
Colitis
GERD
Inflammatory Bowel Disease

GU
Bladder Infection
Chronic Renal Failure
Hypogonadism
Kidney Stones
Prostate Cancer

GYN/OB
Breast Cancer
Menopause
Uterine Fibroids

HEENT
Blindness
Deafness
Glaucoma

Musculoskeletal
Arthritis
Back Pain
Disk Disease
Fibromyalgia

Neurological/Psych
Alcoholism
Anxiety
Migraine
Multiple Sclerosis
Parkinson's
Seizures
Stroke

Respiratory
Asthma
Bronchitis
COPD
Emphysema
Pneumonia
Sleep Apnea

Tumors
Brain Tumor
Breast Cancer
Cervical Cancer
Colon Cancer
Fibrocystic Breast Disease
Gastric Cancer
Leukemia
Lung Cancer
Lymphoma
Ovarian Cancer
Uterine Cancer

SURGICAL HISTORY

Please CIRCLE if you have had any of the following surgeries and date of surgery:

Cadiovascular
Angioplasty
CABG (Heart Bypass)
Defibulator
Pacemaker Insertion
Stents
Other_______________

General
Laminectomy
Pilonidal Cyst Incision
Other_______________

GI
Appendectomy
Cholecystectomy
Colon Resection
Colonoscopy (in past 9 years)
Gall Bladder
Hemorrhoidectomy
Inguinal Herniorphaphy

GU
Biopsy Prostate
ESWL, Stone Blasting
Kidney Stone
Needle Biopsy Prostate
Nephrectomy
Penile Implant
Penectomy (date)
Prostate Seed Implant
Radical Prostatectomy
Stone Extraction
Vasectomy
Other_______________

GYN
Breast Surgery
Delivery Vaginal
Delivery Cesarean
Hysterectomy-Complete
Hysterectomy-Partial
Tubal Ligation Bilateral
Other_______________

HEENT
Cataract Surgery
Nasal Surgery
Sinus Surgery
Tonsil Surgery
Other_______________

Musculoskeletal
Arthroscopic Knee Surgery
Back Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Disc Surgery
Hip Surgery
Knee Surgery
Rotator Cuff Surgery
Other _______________

Respiratory
Lung Surgery
Other ________________

Skin
Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma
Other _________________

Other: ____

____

FAMILY HISTORY

Please indicate which family member has/had any of the following NOT including yourself :
(Mother, Father, Sister, Brother, Grandmother, Grandfather, Uncle, Aunt)

Alcoholism ____________________________
Arthritis ____________________________
Bedwetting ____________________________
Bladder Cancer ____________________________
BPH (prostate) ____________________________
Cancer (site unknown) ______________________
Crohn's Disease ____________________________
Depression ____________________________
Diabetes ____________________________
Gout ____________________________
Heart Attack ____________________________
Hypertension ____________________________

Kidney Cancer ________________________________
Kidney Disease ________________________________
Leukemia ________________________________
Malignant Melanoma ____________________________
Multiple Sclerosis________________________________
Laryngeal Cancer ________________________________
Pancreatic Cancer________________________________
Prostate Cancer ________________________________
Stroke ________________________________
Thyroid Disease ________________________________
Tuberculosis ________________________________
Uterine Cancer ________________________________

Other: ____
____

Father: ☐ alive ☐ deceased age:_______ cause of death ____

Mother: ☐ alive ☐ deceased age:_______ cause of death ____

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Patient Financial Responsibility Agreement

Please arrive **30 minutes** prior to the scheduled time for your first appointment and **15 minutes** before all other appointments. If you are unable to keep your appointment, please call 24 hours before your scheduled time. We reserve the right to apply a $75 fee to your bill for a No Show appointment.

Payment for services is expected at the time they are rendered unless alternative arrangements have been approved in advance, this does includes your copay. We participate with most major insurance carriers. If you have any questions regarding whether we participate in a particular insurance, please don't hesitate to call our office. As a courtesy, we will file office and hospital charges with your insurance carrier(s). Your policy is a contract between you and your carrier; therefore it is your responsibility to understand your coverage, deductible, and coinsurance. All self-pay patients will be asked to pay before services are provided. By signing this letter below, you are authorizing that all insurance benefits be paid directly to Urology Associates of the Poconos, Inc. We accept cash, checks, and most major credit cards. Failure to provide onsite payment may result in a reschedule of your appointment and an additional $5 processing fee. Returned checks will result in a $35 fee. Outstanding balances older than 30 days are subject to additional collection fees and accrued interest charges of 1.5 % per month.

HMO insurance patients, please plan in advance by contacting your Primary Care Physician so the INSURANCE REFERRAL is available prior to your visit. **We are unable to see you without this documentation and we will need to reschedule your appointment.** If tests are ordered, or additional follow up appointments are made, please contact your Primary Care Physician regarding additional referrals.

We realize that temporary financial problems may impede timely payment of your account. If such problems do arise, please contact us promptly for assistance in making arrangements for payment. We reserve the right to refuse to see patients with balances over $250, and who are not making arranged payments. If you have an unpaid balance at the end of a billing cycle and you have not made payment arrangements, we will apply a $25 collection fee.

Printed Name:____________________________ ___________________________________ ________

Signature: Date

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HIPAA Release Form

(Medical Information Release form)

Patient name: ______________________________ **Date of Birth:** ________________

I authorize the release of information including the diagnosis, treatment, examinations & all records rendered about me plus all claims information be released to:

(X) Insurance carriers (Medicare/Medigap/Commercial)

( ) Spouse's Name___________________________________

( ) Child(ren) Name________________________________

( ) Other_____________________________________

( ) Information is not to be released to anyone.

PLEASE NOTE: IF A PERSON IS NOT LISTED ABOVE, WE CANNOT LEGALLY SPEAK TO THEM; THIS INCLUDES SPOUSES, CHILDREN, ETC.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ( ) my home ( ) my work ( ) my cell phone:______________________

If unable to reach me:

( ) we can leave a detailed message

( ) we can leave a message asking you to return our call

Signed: ______________________________________ Date: _____/______/_______