Dennis L. Ortiz, D.O.
Patient Information (Male)

(please print clearly) DATE: _____/_____/_____

First Name: _____ M.I._____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____-_____

Social Security #:_____Birthdate: _____/_____/_____ SEX (Circle One): Male / Female

Circle One: Single / Married / Divorced / Widowed / Separated

Cell Phone: (_____)_____ Home Phone: (_____)_____ Work Phone: (_____)_____

Patient Employer: _____ Occupation: _____

Work Address/City/St/Zip: _____

Spouse or Parent Name: _____ Birthdate: _____/_____/_____

Social Security #: _____ Employer: _____

Work Phone: (_____)_____ Work Address/City/St/Zip: _____

****

Insurance Company: _____ Phone: (_____)_____

ID/Policy #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Insurance address (Complete): _____

****

Please give name, address and phone # of PCP and/or physician who referred you to Dr. Ortiz:

_____

Name, address, phone number and relationship of nearest relative or friend, preferably not living with you, who can be reached in case of emergency:

_____

Pharmacy Name: _____ Location: _____

Phone: (_____)_____ Fax: (_____)_____

PLEASE SEE REVERSE SIDE FOR ADDITIONAL INFORMATION.

PLEASE READ THE INFORMATION BELOW CAREFULLY

The patient is responsible for deductible, co-insurance, co-payments and non-covered services as determined by their Insurance Carrier. We will file for secondary coverage, however, we must be provided with this information.

Patients who carry health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. For insurance companies with which Dr. Ortiz has a contract, the stated co-payments are expected at the time services are rendered, as are calculated coinsurance percentages.

Even though an insurance claim is filed on your behalf, this office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. As the beneficiary, you are responsible for payment of your account within the limits of our credit policy. You will receive a statement once the insurance payment or denial has been received.

It is the responsibility of the insured to keep this office informed of any insurance or primary care physician changes prior to appointments and to ensure that this office has received necessary referrals for specialist care.

PLEASE READ CAREFULLY AND SIGN WHERE APPROPRIATE

For all services provided by Dr. Dennis Ortiz, I hereby assign all medical/surgical benefits, to include major medical benefits, to Dr. Dennis Ortiz. I give permission to Dr. Ortiz to examine and administer such treatment as may be necessary or advisable, based on my diagnosis. I have the right to refuse recommended treatment. I authorize Dr. Ortiz to bill my insurance for services rendered and to provide the insurance company with the necessary information needed in order to properly process and provide payment for my claim. I understand that I am financially responsible for all charges, whether paid or not by my insurance, within the limits of existing contracts with specific carriers. A photocopy of this authorization shall be considered as valid as the original. This authorization can be revoked in writing for any future services provided.

Signed_____Date_____

For Medicare claims, I authorize any holder of medical or other information about me to be released to the Social Security Administration and to CMS or its intermediaries or carriers all necessary information needed in order to properly process and provide payment for my claim. I give permission to Dr. Ortiz to examine and administer such treatment as may be necessary or advisable, based on my diagnosis. I have the right to refuse recommended treatment. I understand that I am financially responsible for non-covered charges and all applicable deductibles and copayment amounts. A photocopy of this authorization shall be considered as valid as the original. This authorization can be revoked in writing for any future services provided.

Signed_____Date_____

I give permission to Dr. Ortiz to examine and administer such treatment as may be necessary or advisable, based on my diagnosis. I agree to abide by any financial arrangements made at the time of service. If at some time in the future I become eligible for insurance coverage, I authorize the release of all necessary information to establish eligibility and determine benefits available. I have the right to refuse recommended treatment. This authorization can be revoked in writing for any future services provided.

Signed_____Date_____

Office Witness_____Date_____

North Central Urology P.A.

ADULT AND PEDIATRIC UROLOGY, BOARD CERTIFIED
4218 Gateway Dr., Suite 100, Colleyville, TX 76034
(817) 283-1860 FAX (817) 283-2175
Answered 24 hours/after hours emergency only

OFFICE POLICY

The following information is presented to assist you in understanding the administration of our office policy.

APPOINTMENTS:

Our office is open Monday through Thursday from 8:30am to 5:30pm, Friday 8:00am to 5:00pm We are out of the office for lunch from 12:00n to 1:00pm

All scheduling of appointments, rescheduling and cancellations must be made through the office during these hours, at extension 202.

A 24 hour advance notice is required for any changes to the schedule.

CHARGES:

Payment is required at the time that services are rendered; if you are not prepared to pay, the appointment will be rescheduled.
WE ACCEPT CASH, CHECK,VISA, AND MASTER CARD ONLY.

There will be a charge for all written forms, reports, or letters which require preparation time, research (professional or medical), or professional or medical decision-making. There will be a charge for release of medical records to anyone other than another physician. A signed medical records release form must be completed.

All patients (Medicare, PPO, HMO, Indemnity) are responsible for their balance after insurance has been filed.

All patients are responsible for updating our office with any changes in responsible party, billing, or insurance information. Patients with Medicare must inform our office of any changes to Medicare carrier, (i.e.: SecureHorizons, PacifiCare, etc.) PRIOR TO any office visit, procedure, or treatment so that a correct and valid referral is on hand, if required.

Disclosure of Physician Ownership

Baylor Medical Center at Trophy Club, Baylor Surgicare at Bedford and I are committed to providing clinical excellence in a safe, comfortable environment for you and your family members. I am a percentage owner of both facilities. This ownership enables me to have a voice in the administration and policies of both facilities. This involvement helps to ensure the highest quality of care for you.

Baylor Medical Center at Trophy Club and Baylor Surgicare at Bedford both meet the Federal definition of a physician-owned facility and a list of each facility's owners that are physicians (or their immediate family members) is available from either facility upon your request.

If you have any questions concerning this notice, please feel free to ask Dr. Dennis Ortiz or the Chief Executive Officer at either Baylor Medical Center at Trophy or Baylor Surgicare at Bedford. We welcome you as a patient and value our relationship with you.

I have received a copy of this notice:

_____ _____ Printed Name:_____

Patient or responsible party

Date:_____

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date_____ Date of Last Physical Exam _____

Patient Name_____ SS # :_____DOB:_____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

_____
_____
_____

History of Present Illness

Please answer the following questions.

Location of the problem
Abdomen Back Leg
Other_____
_____
_____

On a scale of 1-10, with 10 being the most severe, circle one number that best describes the problem
1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other _____

Does anything help or make the problem worse?
Moving around Standing up Lying on my side
Other_____

How long does the problem last?
30 minutes 1 hour It's always there
Other_____

Is anything else occurring at the same time?
Yes No If yes, please explain.
Nausea Rash Headaches
Other_____

Is the problem constant or variable?
Dull then sharp Very sharp then leaves Always there
Other_____

Does the problem interfere with your normal functions?
Yes No If yes, please explain_____
_____

_____

Physician use only: (Comments/Notes)

# Answer	Level of Service
1-3	1 or 2
4+	3 - 5

_____

Past Medical and Social History

List all serious illnesses in your immediate family. (example: diabetes, tuberculosis, cancer of chest, cardiac disease, etc.)

_____ _____ _____
_____ _____ _____

List any personal past illnesses and or surgeries and when they occurred.
Illness or Surgery Date
_____
_____

Do you smoke? Y N
If yes, how much? _____
Do you drink? Y N
If yes, how much _____

Are you on any medications: Y N (please list)
_____ _____
_____ _____

Are you on a special diet? Y N (explain)
_____

Do you have allergies? Y N (please explain)
_____
_____

_____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0	1 or 2
1-2	3
3	4 or 5

AUA SYMPTOM SCORE (AUASS)

PATIENT NAME: _____ **TODAY'S DATE:** _____

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	LessThan Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or More Times
Over the past month, how many times per night 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?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right. **TOTAL:** _____

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

BLADDER SATISFACTION SURVEY

Name_____ Phone #_____

Doctor _____

Which symptoms best describe you? (Circle All That Apply)

□Frequent Urination – Day, Night, or Both
□Sudden or Strong Urge to urinate
□Unable to empty the Bladder
□Leaking with Sneezing, Coughing, Exercising
□Leaking with Urge or No Warning (Unable to make it to the bathroom in time)
□Bladder or Pelvic Pain

How long have you had these symptoms? _____

Have you tried medications to help your symptoms? □Yes □No

If yes, circle the medications you have tried:

□Detrol® LA □Ditropan XL® □Flomax® □Cardura® □Gelnique®

□Oxytrol® Patch □Enablex® □VESIcare® □DDAVP® □Toviaz®

□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: (Circle All That Apply)

□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? (Circle All That Apply)
□Fecal Incontinence □Constipation □Other

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

