# *North Central Urology P.A.*


## *Dennis L. Ortiz, D.O.*

**ADULT AND PEDIATRIC UROLOGY**
**BOARD CERTIFIED**
**4218 Gateway Dr., Suite 100 Colleyville, TX 76034**
**(817) 283-1860 FAX (817) 283-2175**


**Patient Information**

□ **Dr.** □ **Miss** □ **Mr.** □ **Mrs.**

Patient's Name (Last) ______________________________(First) ____________________________ (MI) __________

Address ______________________________________________________________________________________

City, State ______________________________ Zip_____________ Date of Birth MM ______/DD_______/YY_______

Home ____________________ Cell No. _______________________ Work Phone___________________ Ext. ________

Social Security Number _________-_____-_________ Sex □ Female □ Male

Primary Care Provider (PCP) ______________________________ Referring Provider ___________________________

Language □ English □ Spanish Marital Status □ Married □ Single □ Divorced □ Widowed □ Separated

E-Mail Address _______________________________@________________________

Employer Name & Address ____________________________________________________________________________

Emergency Contact (Last name) __________________________ (First name) _________________________________

Phone Number _________________________ Relationship _____________________________

Address ______________________________________________________________________________________

City, State ______________________________ Zip ________________

**Responsible Party Information**___________________________________(information used for patient balances)

Responsible Party □ Another patient □ Guarantor □ Self Check here if information is same as patient □

Responsible Party Name (Last) _______________________ (First) _________________________ (MI) __________

Date of Birth MM______/DD______/YY______ Sex □ Male □ Female Social Security Number ______-___-______

Address ______________________________________________________________________________________

City, State _______________________________ Zip___________________

Telephone Number _______________________ E-Mail ___________________________@_______________________

Employer Name/ Address _______________________________________________________________________

Employer Phone Number _____________________________

**Primary Insurance Information**

Insurance Company/Phone Number _______________________________________ (_____)________________________

Name of Insured ___________________________________ Relationship to Insured___________________________

Date of Birth MM______/DD______/YY______ Effective Date ___________________________

Subscriber ID (Policy Number) _______________________________________ Group ID _________________________

**Secondary Insurance Information**

Insurance Company/Phone Number _______________________________________ (_____)________________________

Name of Insured ___________________________________ Relationship to Insured___________________________

Date of Birth MM______/DD______/YY______ Effective Date ___________________________

Subscriber ID (Policy Number) _______________________________________ Group ID _________________________

I agree that the information on this form is accurate and up-to-date to the best of my knowledge.

Pharmacy Name, Address & Phone: _____________________________________________ (     ) __________________

**PLEASE READ THE INFORMATION BELOW CAREFULLY**

**The patient is responsible for deductible, coinsurance, 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 North Central Urology (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.

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**PLEASE READ CAREFULLLY AND SIGN WHERE APPROPRAITE**

For all services provided by Dr. Ortiz, I hereby assign all medical/surgical benefits, to include major medical benefits, to Dr. 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.

Patient Signature ________________________________ 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 ne 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.

Patient Signature________________________________ Date _____________________

I give permission to Dr. Ortiz to examine and administer such treatment as may ne necessary or advisable, based on my diagnosis. I have the right to refuse recommended treatment. 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. This authorization can be revoked in writing for any future services provided.

Patient Signature ________________________________ Date ________________________

Office Witness ________________________________ Date _________________________

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Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost-effective medical care. Together, we (patients and your healthcare team) are trying to adapt to the changing ways that healthcare is financed and delivered. The following guidelines were developed to help you through the process.

**Payment Guidelines:**

- We collect co-payments, co-insurance, and/or deductibles at the time of service, unless other written arrangements have been made in advance with our office. Surgery deposits must be made prior to the day of surgery.
- We accept **Cash, Checks, Money Orders, and Credit Cards (Visa, Mastercard, American Express and Discover).**
- If your check is returned, a processing fee of $35 will be assessed in addition to the amount of the check.
- A claim will be sent to your insurance company for payment. If you insurance company remits the payment to you, please send the payment to our office, along with the Explanation of Benefits.
- Any balance that your insurance company determines to be your financial responsibility will be billed to you. Payment is due in full upon receipt of your statement. Balances that remain unpaid after 90 days may be referred to an outside collection agency for further collection efforts. __________ (initial)

**No Show / Late Cancellations:** To provide the best possible service and availability to all patients, our practice has implemented the following fees:

_______ (Initial) **Office Visit** – We require a 24-hour notice for all office visit cancellations. If the required notice is not given, a $50.00 charge will be assessed to the patient account.

_______ (Initial) **Procedure** – We require a 2 business day notice for all procedure cancellations. If the required notice is not given, a $100.00 charge will be assessed to the patient account.

The missed appointment payment may be required prior to, or upon the next scheduled procedure or office visit.

**Ancillary Services:** Your physician may refer you to one or more “ancillary services” in connection with your medical care. An ancillary service is a service supplementing or supporting your medical treatment. The following are considered, but not limited to, possible ancillary services:

- Ambulatory Surgery Center
- Infusion Therapy
- Laboratory & Pathology Testing
- Pharmacy Services
- Radiation/Imaging

Your physician may have an economic interest in, or business relationship, with the company or person who provides the ancillary service(s). You are not obligated to use the provider that your physician refers you to. You are free to use any provider you choose.

**Research Programs:** Your physician may ask if you would like to participate in a clinical trial or research program. These programs may be sponsored by a drug company or may be a practice-sponsored research program. Your physician may be compensated for services rendered in connection with these programs. You are not obligated to participate in any research program and your permission will be obtained prior to your participation in a program that your physician believes may be appropriate for you.

**When to present your insurance card:** Please present your insurance card at **EACH VISIT**. Specifically, bring to our attention any changes (new card, new subscriber or group number, etc.) since your last visit. This protects you from paying a bill due to providing incorrect information. There is a narrow window (0-45 days) to present an accurate claim to the correct insurance company. Failure to do so could mean the claim may be denied. If you have a secondary insurance it will be filed as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

**Assignment of Benefits:** North Central Urology may file a claim for services rendered by the physician, facility, pathologist and or anesthesia provider. North Central Urology is authorized to transfer any patient overpayment to one of these associated entities if applicable. I hereby authorize North Central Urology to:

- Release any information necessary to the insurance company regarding my illness and treatments.
- Process claims generated for my examination/treatment.
- Allow a photocopy of my signature to be used to process insurance claims for a period of a lifetime.
- Keep this order in effect until it is revoked by me in writing.

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**Disclosure of 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 Club or Baylor Surgicare at Bedford. We welcome you as a patient and value our relationship with you.

We value you as a patient and we are eager to serve you! Our priority is to provide you with the best possible care. If you would like to contact our office, you may do so at 817-283-1860.

I have read and understand the guidelines, financial obligations, and disclosure as stated above.

________________________________________
Patient or Responsible Party Signature

________________________________________
Printed Name

________________________________________
Date

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## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rules gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply)**

**□ Home Telephone ___________________________**

- **□ O.K. to leave a message w/ detailed information**
- **□ Leave a message w/call back number only**

**□ Work Telephone ____________________________**

- **□ O.K. to leave a message w/ detailed information**
- **□ Leave a message w/call back number only**

**□ Written Communication**

- **□ O.K. to mail to home address**
- **□ O.K. to mail to my work/office address**

**Authorized persons to disclose information to:**

**Name:** _____________________________ **Phone:** _______________________ **Relationship:** ____________________

**Name:** _____________________________ **Phone:** _______________________ **Relationship:** ____________________

**Name:** _____________________________ **Phone:** _______________________ **Relationship:** ____________________

**Name:** _____________________________ **Phone:** _______________________ **Relationship:** ____________________

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

_______________________________________ _________/_________/_________

Patient Signature Date

_______________________________________ _________/_________/_________

Patient Name Birthdate

# North Central Urology

## History of Present Illness

Patient Name :_______________________________________________ Date of birth : _____/_____/_____

**What is the main reason for your visit:**

☐ Elevated PSA
☐ Erectile Dysfunction
☐ History of Bladder Cancer
☐ Vasectomy
☐ Kidney Stones
☐ Bladder Tumor

☐ History of Kidney Caner
☐ Urinary Tract Infections
☐ Infertility
☐ History of Prostate Cancer
☐ Abdominal or flank pain
☐ Renal/Kidney Cyst

Blood in urine ☐ visible ☐ invisible
☐ BPH or male voiding symptoms or Incontinence or female voiding symptoms
☐ Other Specify___________________
________________________________
________________________________

**Complete the following section if the reason for today's visit is for incontinence (male or female):**

How many episodes of incontinence do you have in a typical daytime period? _________________

How many episodes of incontinence do you have in a typical nighttime period? ________________

**Are you incontinent with…**

Coughing? ◻ Yes ◻ No

Sneezing? ◻ Yes ◻ No

Walking? ◻ Yes ◻ No

Physical Activity? ◻ Yes ◻ No

Are you bothered by a need to hurry to get to the bathroom? ◻ Yes ◻ No

Are you incontinent because you cannot get to the bathroom in time? ◻ Yes ◻ No

Do you wear pads to manage incontinence? ◻ Yes ◻ No

If yes, type of pad _______ # pads per day______ # pads per night ______

Last treatment date for urinary tract infection …………………….______/______/______

**Do you have…**

Stroke or head injury? ◻ Yes ◻ No

Back injury or surgery? ◻ Yes ◻ No

Past radiation therapy? ◻ Yes ◻ No

Weak or numb legs? ◻ Yes ◻ No

(Women only) Number of pregnancies/deliveries ______/______

**Tobacco History**

Are you an active smoker? ◻ Yes ◻ No

Have you ever been a cigarette smoker? ◻ Yes ◻ No

If yes, I smoked an average of ___ packs per day for ___ years. I quit in _____ (year)

Do you use other tobacco products?

If yes, please specify ______________________________________________________________

**Alcohol and Drug History**

Do you currently drink alcohol? ◻ Yes, currently ◻ Never/rarely If yes, how many drinks per week(beer, wine, liquor)

______________________________________________________________________________

# North Central Urology

## History of Present Illness

Patient Name :_______________________________________________ Date of birth : _____/_____/_____

**MEDICAL CONDITIONS** (include past and present medical conditions. check appropriate box)

| | Yes | No |
|---|---|---|
| High Blood Pressure (hypertension) | ◻ | ◻ |
| Elevated Cholesterol | ◻ | ◻ |
| Irregular Heart Beat (cardiac arrhythmia) | ◻ | ◻ |
| Congestive Heart Failure | ◻ | ◻ |
| Stroke or TIAs | ◻ | ◻ |
| Ulcers of stomach or intestine | ◻ | ◻ |
| Emphysema, COPD,or lung problems | ◻ | ◻ |
| Asthma | ◻ | ◻ |
| Diabetes | ◻ | ◻ |
| Bleeding problems | ◻ | ◻ |
| HIV/AIDS | ◻ | ◻ |
| Kidney Disease (renal failure) | ◻ | ◻ |
| Liver Disease (hepatitis B or C) | ◻ | ◻ |
| Seizures | ◻ | ◻ |
| Thyroid Disease | ◻ | ◻ |
| Psychological or psychiatric disease | ◻ | ◻ |
| Cancer of any organ (specify) | ◻ | ◻ |
| Kidney Stones | ◻ | ◻ |
| Glaucoma | ◻ | ◻ |

List any other conditions ____________________________________________________________________

____________________________________________________________________________________________

**Family History**

| **Is there a history in your family of:** | **Yes** | **No** |
|---|---|---|
| High Blood Pressure | ◻ | ◻ |
| Diabetes | ◻ | ◻ |
| Prostate Cancer | ◻ | ◻ |
| High Cholesterol | ◻ | ◻ |
| Kidney Stones | ◻ | ◻ |

Other significant disease ____________________________________________________________________

# North Central Urology

## History of Present Illness

Patient Name :_______________________________________________ Date of birth : _____/_____/_____

**CURRENT MEDICATIONS**

(include prescription, over the counter and herbal supplements) or ☐ None

| Name of Medication | Dose (mg) | How offten is the medication taken |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
| 11 | | |
| 12 | | |
| 13 | | |

**ALLERGIES** (include medications,foods,x-ray dyes) or ☐ None known

| Name of Allergen | Type of reaction |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |

**Past Surgeries** (include all surgeries in your lifetime) or ☐ None Please list any additional on the back

| Type of Surgery | Date (approximate) |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| 7 | |
| 8 | |
| 9 | |
| 10 | |

# North Central Urology

## History of Present Illness

Name: ______________________________________ Date of Birth: ______/______/______

Doctor: __________________________

**Which symptoms best describe you? (Check all that apply)**

□ Frequent Urination- Day, Night, or Both

□ Sudden or Storng Urge to Urinate

□ Unable to empty the Baldder

□ 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 the symptoms?** _______________________________________

**Have you tried medications to help your symptoms?**

□ Detrol LA □ Ditropan XL □ Flomax □ Cardura □ Gelnique
□ Oxytrol Patch □ Enablex □ VESIcare □ DDVAP □ Toviaz
□ Sanctura □ Elavil □ Elmrion □ 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: (Check 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 frsutration 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? (check all that apply)**

☐ Fecal Incontinence ☐ Constipation ☐ Other

**I am interested in learning more about treatment alternatives to medicines:**

☐ Yes ☐ No

# NEW PATIENT HISTORY FORM

**Name:** ___________________________________

( Please fill in the bubbles carefully and completely for each question)

Psychology

Depression o Yes o No
High stress level o Yes o No
Sleep disturbances o Yes o No
Aniexty o Yes o No
Are you satisfied with life? o Yes o No
Dou you think of suicide? o Yes o No

**Constitutional**

Weight gain o Yes o No
Loss of appetite o Yes o No
Fever o Yes o No
Weakness o Yes o No
Weight loss o Yes o No
Fatigue o Yes o No
Chills o Yes o No
Headache o Yes o No

**Ear Nose & Throat**

Cold o Yes o No
Cough o Yes o No
Nose bleed o Yes o No
Hearing loss o Yes o No
Sore throat o Yes o No
Ringing in ears o Yes o No
Sinus pain o Yes o No
Ear infection o Yes o No
Sinus problems o Yes o No

**Cardiology**

Chest pain o Yes o No
Palpitations o Yes o No
Leg edema o Yes o No
Shortness of breath o Yes o No
Varicose veins o Yes o No
High blood pressure o Yes o No

Blood in stool o Yes o No
Diarrhea o Yes o No
Constipation o Yes o No
Nausea/vomiting o Yes o No
Difficulty swallowing o Yes o No
Abdominal Pain o Yes o No
Heartburn/Indigestion o Yes o No
Hemorrhoids o Yes o No

**Neurology**

Headache o Yes o No
Tingling/numbness o Yes o No
Seizures o Yes o No
Insomnia o Yes o No
Memory Loss o Yes o No
Dizziness o Yes o No

**Heamtology/Lymph**

Swollen glands o Yes o No
Fatigue o Yes o No
Loss of appetite o Yes o No
Varicose veins o Yes o No
Easy bruising o Yes o No
Blood clotting problem o Yes o No

**Urology**

Difficulty urinating o Yes o No
Blood in urine o Yes o No
Frequent urination o Yes o No
Voiding dysfunction o Yes o No
Nocturia o Yes o No
Recurrent UTI o Yes o No
Urine retention o Yes o No

**Eyes**

Blurred vision o Yes o No
Double Vision o Yes o No
Pain o Yes o No

**Allergy/Immunologic**

Hay Fever o Yes o No
Drug Allergies o Yes o No

**Endocrine**

Excessive thirst o Yes o No
Too hot/cold o Yes o No
Tired/sluggish o Yes o No

**Integumentary-Skin**

Skin rash o Yes o No
Boils o Yes o No
Persistant itch o Yes o No

**Musculoskeletal**

Joint pain o Yes o No
Neck pain o Yes o No
Back pain o Yes o No
Flank pain o Yes o No

**Respiratory**

Wheezing o Yes o No
Frequent cough o Yes o No
Shortness of breath o Yes o No

**Social History**

Alcohol o Yes o No
Smoking o Yes o No
Sexually active o Yes o No
Exercise o Yes o No
Recreational drug use o Yes o No
Caffeine o Yes o No
Travel outside US o Yes o No
Occupational exposure o Yes o No
Occupation o Yes o No

## Sign up for the patient portal to view Medical Records:

EMAIL (please print): ________________________________________@_____________________________________