Name: ____ **Date:** __________________________

Referring Doctor: _______________________________**Family Doctor:** _______________________________

Home Address: ____

City: ____________________________________State: ___________ Zip Code: _____________________

Home Phone: ________________ Cell Phone: ___________________ Work Phone: ___________________

SSN: __________________________________ Date of Birth: ______________________ Gender: ________

Race: _________________________ Ethnicity: ______________________ Language: ____________________

Email Address: ____

Work Name & Address: ____

____Profession: ____

Spouse's Name: __________________________________ Contact Number: _____________________

Emergency Contact: ___________________ Phone Number: ___________ Relationship: ___________

Medical Information Release and Assignment of Benefits:
I authorize the release of any medical information necessary to process my insurance claim. I permit a copy of this authorization to be used in place of the original.

Patient Signature: ____ *Date:* _______________

I hereby authorize Jeffrey A. Snyder, M.D., F.A.C.S., to apply for benefits on my behalf for covered services rendered by him, his staff or by his order. I request that payment from my insurance company be made directly to Jeffrey A. Snyder, M.D., F.A.C.S., (or to the party that accepts assignment.)
I certify that the information I have reported with regard to my insurance coverage is correct.
I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Patient Signature: ____ *Date:* _______________

Why are you seeing the doctor today? ____

How long have you had this problem? ____

What improves or worsens the problem/pain? ____

Are there any symptoms that go along with the problem/pain? _______________________________________

Is the problem/pain continuous or does it come and go? ____

Describe the pain (sharp/dull, etc.) ____

Have you tried any medicine/treatment for this problem/pain? _______________________________________

RELEASE OF INFORMATION

I give permission to Genitourinary Surgical Consultants to relay my medical information to:
(check all that apply)

_______ Leave a detailed message at this number ______________________

_______ My Spouse. Name: ____

_______ My Children. Name: ____

_______ I elect to have ALL medical information relayed directly to myself.

Print Name: ____

Patient Signature: ____

Date: ________________________ Best Contact Number: ______________________

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Jeffrey A. Snyder, M.D., F.A.C.S. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. The Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices (located on the window sill in the waiting room).

I acknowledge that I have received a copy of the Notice of Privacy Practices of Jeffrey A. Snyder, M.D., F.A.C.S.

Name: ____

Signature: ____

Date: ____

Name and Signature of Personal Representative: ____________________________

____

GENITOURINARY SURGICAL CONSULTANTS

Office Policies

We strive to provide high quality care in a friendly setting. To help us reach our goal, the following policies are in place for our practice. Please read and INITIAL next to every policy. Thank you.

___ **OFFICE VISITS**: *All office visits are to be scheduled. Please call our office before coming in. If you believe you have an urgent situation, please call us before coming in. If you are more than 15 minutes late, you may be asked to reschedule.*

___ **CANCELLATIONS/NO SHOWS:** *To provide high quality care and in fairness to other patients and the providers, we require at least one business day/24 hours notice to cancel appointments. There will be a* **$50.00** *fee for the second missed or late cancelled appointment without proper notification, which will be due and payable from you. There will be a* **$150.00** *charge for a missed/late cancelled procedure appointment. The practice reserves the right to dismiss patients with three missed or late cancelled appointments.*

___ **TELEPHONE CALLS:** *We strive to return phone calls in a timely manner. We ask you to reserve after hours phone calls for urgent matters only, save routine and non-urgent questions for office hours.*

___ **PERSONAL INFORMATION:** *All information will be verified each visit. If you have changed any information (address, phone number, insurance, etc), it is your responsibility to notify the front desk. We will bill your insurance as a courtesy if the appropriate information is provided.*

___ **PAYMENT REQUIREMENTS:** *Co-pays are due at the time of service. We accept cash, personal check, Visa and MasterCard. We reserve the right to refuse payment in the form of a check if there are checks returned on your account. We charge $35.00 on all returned checks. In the event that we must re-bill you, there could be a rebilling charge.*

___ **HEALTH INSURANCE:** *As a service to you, we will accept assignment of benefits and will bill your insurance carrier, provided proper paperwork is provided to us. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, but the ultimate responsibility for the unpaid balance rests with you. Please understand that insurance is a contract between you and your insurance carrier. If an insurance carrier has not paid within 60 days of billing, any unpaid fees are due and payable in full from you.*

___ **NON-COVERED CHARGES:** *Any charges not paid by your insurance carrier will require payment in full at the time of service or upon notice of insurance claim denial. The billing policy can only be overridden by the practice manager.*

This acknowledges that I have read, agreed and had the opportunity to ask questions about these policies.

Patient Printed Name: ____

Patient Signature:______________________________**Date:** ________________

4500 East Ninth Avenue, Suite 530 • Denver, Colorado 80220
Ph: 303.320.0200 • Fax: 303.320.4111 • www.snyderurology.com

<u>CURRENT MEDICATIONS</u> – **Please list ALL medications you are currently taking including over the counter meds**

Drug Name: **Strength:** **Directons/How you take it:**

_______________________________ _____________ ____

_______________________________ _____________ ____

_______________________________ _____________ ____

Attach list if necessary

Pharmacy Name: ____ **Phone #:** ____

<u>ALLERGIES</u> – **Please list ALL types (Drug, seasonal, pets, environmental foods)**

____

____

By what method did you choose our practice:

______Referring Physician ______Friend ______Yellow Pages______Insurance Company_____Other

SOCIAL HISTORY

<u>Please provide the following information:</u>

Marital Status: Please indicate years

______ Single ______Married ______Separated _____Divorced _____Widowed _____Life Partner ____Common Law Spouse

Dependants: Please indicate # of each, if you have:

_____Sons ______Daughters ______Stepchildren ______Adopted ______Foster ______Parents _______Grandparents

Alcohol Consumption:

_____None _____Yes _____Occasional/Social # of drinks per day _______

Tobacco per day:

_____None ______Yes #_______Packs/day ______Cigarettes/day _____Smokeless Tobacco

If you previously stopped, When? ___________________________

Recreational Drugs: ______None If yes, please list: ____

Caffeinated beverages: None Low Moderate Excessive

Recent Travel: None Americas __________________ Worldwide _______________________________

Name: _______________________________________Date: ___________________________

PAST MEDICAL HISTORY Please select if you have or have had any of the following diseases or conditions:

Cardiovascular

- ☐ Anemia
- ☐ Angina
- ☐ Anorexia
- ☐ Aortic Aneurysm
- ☐ Aortic Regurgitation
- ☐ Aortic Stenosis
- ☐ Arrhythmia
- ☐ Atrial Fibrillation
- ☐ Bleeding Disorder
- ☐ Cardiomyopathy
- ☐ Cerebrovascular Disease
- ☐ Claudication
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Endocarditis
- ☐ Enlarged Heart
- ☐ Heart Attack
- ☐ Heart Block
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Problem
- ☐ Hemophilia
- ☐ Hypertension, well controlled
- ☐ Hypertension, progressive
- ☐ Hypertension, severe
- ☐ Leukemia
- ☐ Mitral Insufficiency
- ☐ Mitral Stenosis
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Thrombophlebitis
- ☐ Varicose Veins
- ☐ Ventricular Arrhythmia

Endocrine/Metabolic

- ☐ Diabetes Mellitus, non-insulin dependent
- ☐ Diabetes Mellitus, insulin dependent
- ☐ Diabetes Mellitus, uncontrolled
- ☐ Goiter
- ☐ Gout
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Impaired Glucose Tolerance

General

- ☐ Allergies
- ☐ Electrical Injury
- ☐ Exposure to Chemicals
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hypercholestolemia
- ☐ Hyperlipidemia
- ☐ Infectious Disease
- ☐ Lipid Disorder
- ☐ Malaise
- ☐ Obesity
- ☐ Paget's Disease
- ☐ PCKD
- ☐ PCO
- ☐ Raynaud's Syndrome
- ☐ Sleep Apnea

GI

- ☐ Cholecystitis
- ☐ Cholelithiasis
- ☐ Chronic Liver Disease
- ☐ Colitis
- ☐ Constipation
- ☐ Colon Condition
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ GERD
- ☐ Hemorrhoids
- ☐ Hepatic Failure
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ Inflammatory Bowel Disease
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Peptic Ulcer (Duodenal)
- ☐ Rectal Fissure
- ☐ Stomach Ulcer
- ☐ Ulcerative Colitis

GU

- ☐ AIDS
- ☐ Bladder Outlet Obstruction
- ☐ Bladder Stone
- ☐ Bladder Infection
- ☐ Chronic Renal Disease
- ☐ Chronic Renal Insufficiency
- ☐ Chronic Renal Failure
- ☐ Crossed Fused Ectopia
- ☐ Hematuria
- ☐ Impotence of Organic Origin
- ☐ Interstitial Cystitis
- ☐ Irradiation Therapy
- ☐ Kidney Cancer
- ☐ Kidney Disease
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Libido Decreased
- ☐ Nephrolithiasis
- ☐ Nephrotic Syndrome
- ☐ Neurogenic Bladder
- ☐ Orchitis
- ☐ Penile Discharge
- ☐ Polycystic Disease
- ☐ Polycystic Kidney Disease
- ☐ Prostate Cancer
- ☐ Radiation or Nuclear Exposure
- ☐ Recurrent UTI
- ☐ Renal Cell Cancer
- ☐ Renal Failure
- ☐ Renal Insufficiency
- ☐ Testicular Cancer
- ☐ Transplant Recipient
- ☐ Transitional Cell CA Bladder
- ☐ Transitional Cell CA Ureter
- ☐ Undescended Testicle (Birth)
- ☐ Urinary Tract Infection
- ☐ Venereal Disease

GYN/OB

- ☐ Breast Cancer
- ☐ Breast Disease
- ☐ Endometriosis
- ☐ Menopause
- ☐ Menstrual Problems
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Uterine Fibroids

HEENT

- ☐ Blindness
- ☐ Cataracts
- ☐ Deviated Septum
- ☐ Deafness
- ☐ Ear Infections
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Meniere's
- ☐ Mumps
- ☐ Sinusitis
- ☐ Tinnitus
- ☐ Vertigo

Musculoskeletal

- ☐ Arthritis
- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Claudication
- ☐ Fibromyalgia
- ☐ Morton's Neuroma

Neurological/Psychological

- ☐ ADD
- ☐ ADHD
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Bi-polar Disorder
- ☐ Chronic Fatigue Syndrome
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Herniated Disc
- ☐ Mental Illness
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Nervous Breakdown
- ☐ Organic Brain Syndrome
- ☐ Parkinson's
- ☐ Polio
- ☐ Seizures
- ☐ Spinal Cord Injury
- ☐ Stroke
- ☐ Suicide Attempt

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Lung Disease
- ☐ COPD
- ☐ Emphysema
- ☐ Lung Disease
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Tuberculosis

Tumors

- ☐ Brain Cell Carcinoma
- ☐ Brain Tumor
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Fibrocystic Breast Disease
- ☐ Gastric Cancer
- ☐ Laryngeal Cancer
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Melanoma
- ☐ Ovarian Cancer
- ☐ Pancreatic Cancer
- ☐ Rectal Cancer
- ☐ Rectal Cancer
- ☐ Rectal Cell Cancer
- ☐ Sarcoidosis
- ☐ Testicular Cancer
- ☐ Transitional Cell CA Bladder
- ☐ Transitional Cell CA Ureter
- ☐ Uterine C

Other: ____

Name:______________________________________ **Date:** _________________________

REVIEW OF SYSTEMS: **Please select if you currently have any of the following diseases or conditions:**

Constitutional
- ☐ Appetite Changes
- ☐ Anorexia
- ☐ Aches and Pains
- ☐ Chills
- ☐ Easy Bruising
- ☐ Fever
- ☐ Fatigue
- ☐ Generalized Weakness
- ☐ Insomnia
- ☐ Night Sweats
- ☐ Sleep Apnea
- ☐ Swollen Glands
- ☐ Weight Gain
- ☐ Weight Loss

Eyes
- ☐ Blind
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Pain
- ☐ Worsening Eyesight

Allergic/Immunologic
- ☐ Animal Allergies
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies

Neurological
- ☐ Balance Problems
- ☐ Disoriented
- ☐ Dizzy Spells
- ☐ Headache
- ☐ Lack of Alertness
- ☐ Leg or Arm Weakness
- ☐ Memory Loss
- ☐ Numbness/Tingling
- ☐ Stroke
- ☐ Speech Problems
- ☐ Tremors

Endocrine
- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Pituitary Disease
- ☐ Thyroid Disease
- ☐ Tired/Sluggish
- ☐ Too Hot/Cold

Gastrointestinal
- ☐ Abdominal Cramps
- ☐ Abdominal Pain
- ☐ Acid Reflux
- ☐ Bloody Stools
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Flatulence
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion/heartburn
- ☐ Irregular Bowel Movements
- ☐ Nausea/vomiting
- ☐ Rectal Bleeding
- ☐ Tarry Stool

Cardiovascular
- ☐ Chest Pain/Angina
- ☐ Dyspnea on Exertion
- ☐ Edema
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Mitral Valve Prolapse
- ☐ Orthopnea
- ☐ Pain/Cramps Hips/Legs w/exercise
- ☐ Palpitation
- ☐ Skipped Heart Beats
- ☐ Swelling

Skin
- ☐ Acne
- ☐ Boils
- ☐ Changing Moles
- ☐ Persistent Itch
- ☐ Pigment Change
- ☐ Skin rash

Musculoskeletal
- ☐ Arthritis
- ☐ Back Pain
- ☐ Gout
- ☐ Joint Pain
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Neck Pain/Stiffness

Ear/Nose/Throat
- ☐ Ear Infection
- ☐ Sinus Problem
- ☐ Sore Throat

Genitourinary
- ☐ Back Pain
- ☐ Bedwetting
- ☐ Blood in Urine
- ☐ Dribbling
- ☐ Burning on Urination
- ☐ Erection Problems
- ☐ Flank Pain
- ☐ Hematuria
- ☐ Hesitancy
- ☐ Kidney Failure
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Leak after voiding
- ☐ Nocturia
- ☐ Nocturnal Enuresis
- ☐ Not Emptying
- ☐ Painful Ejaculation
- ☐ Stranguria
- ☐ Stones
- ☐ Suprapubic Pain
- ☐ Urgency
- ☐ Urinary Frequency
- ☐ Urinary Hesitancy
- ☐ Urinary Incontinence
- ☐ Urinary Tract Infections
- ☐ Urine retention
- ☐ Urologic Cancer
- ☐ Urologic Surgery
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge/Problems
- ☐ Weak Stream

Respiratory
- ☐ Asthma
- ☐ Emphysema-Bronchitis
- ☐ Environmental Allergies
- ☐ Frequent Cough
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ Wheezing

Hematological/Lymphatic
- ☐ Swollen Glands
- ☐ Blood clotting problem
- ☐ Bleeding Problem
- ☐ Hepatitis
- ☐ HIV (AIDS)
- ☐ Sickle Cell

Psychologic
- ☐ Anxiety
- ☐ Depressed
- ☐ Generally satisfied with life

Other: ____

____

Name: ____Date: ____________________

SURGICAL HISTORY

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

Cardiovascular
- ☐ Angioplasty
- ☐ Aortic Aneurysm Repair
- ☐ CABG
- ☐ Carotid Artery Surgery
- ☐ Heart Surgery
- ☐ Heart Surgery (Stents)
- ☐ Heart Transplant
- ☐ Pacemaker Insertion
- ☐ Vein Stripping

General
- ☐ Brain Surgery
- ☐ Laminectomy
- ☐ Lymphatic Node Dissection
- ☐ Parathyroidectomy
- ☐ Pilondial Cyst Incision
- ☐ Skin Grafting

GI
- ☐ Appendectomy
- ☐ Bariatric Surgery
- ☐ Bowel Resection
- ☐ Cholecystectomy
- ☐ Colon Resection
- ☐ EGD
- ☐ EGD/Dilation Esophagus
- ☐ Fissurectomy
- ☐ Gastric Surgery
- ☐ Hemorrhoidectomy
- ☐ Ileostomy
- ☐ Laparoscopy
- ☐ Liver Surgery
- ☐ Liver Transplant
- ☐ Lumpectomy of Breast
- ☐ Lysis Adhesions
- ☐ Nissen Fundoplication
- ☐ Splenectomy
- ☐ Stomach Surgery
- ☐ Umbilical Hernia
- ☐ Ventral Hernia Repair

GU
- ☐ Bladder Surgery
- ☐ Biopsy Prostate
- ☐ Brachytherapy
- ☐ Circumcision
- ☐ Contigen
- ☐ Cystoscopy
- ☐ Cystoscopy-Dilation
- ☐ Cystoscopy-Retrograde
- ☐ Cystoscopy-Stent
- ☐ Cysto-TUR Fulguration
- ☐ Durasphere
- ☐ Epididymectomy
- ☐ ESWL
- ☐ Herniorrhaphy
- ☐ Hydrocelectomy
- ☐ Ileal conduit
- ☐ Indigo Laser Surgery
- ☐ Inguinal Herniorraphy
- ☐ Interstim
- ☐ Kidney Stone
- ☐ Laser Lithotripsy
- ☐ Meatotomy
- ☐ Needle Biopsy Prostate
- ☐ Nephrectomy
- ☐ Nephrolithotomy
- ☐ Orchiectomy
- ☐ Orchiopexy
- ☐ Penile Implant
- ☐ Penectomy
- ☐ Penile Surgery
- ☐ Pyeloplasty
- ☐ Radical Prostatectomy
- ☐ Renal Transplant
- ☐ Spermatocelectomy
- ☐ TUMT Prostate
- ☐ TUNA Prostate
- ☐ TURBT
- ☐ TUR Prostate
- ☐ Ureteroscopy
- ☐ Variocelectomy
- ☐ Vasectomy
- ☐ VLAP

HEENT
- ☐ Cataract Surgery
- ☐ Corneal Surgery
- ☐ Ear Surgery
- ☐ Eye Surgery
- ☐ Facial Surgery
- ☐ Mastoid Surgery
- ☐ Nasal Surgery
- ☐ PEG
- ☐ PE Tubes
- ☐ Septoplasty
- ☐ Sinus Surgery
- ☐ Tonsil Surgery
- ☐ Thyroid Surgery
- ☐ TMJ Surgery

Musculoskeletal
- ☐ Amputation
- ☐ Arthroscopic Knee Surgery
- ☐ Back Surgery
- ☐ Carpal Tunnel Surgery
- ☐ Cervical Spine Surgery
- ☐ Disc Surgery
- ☐ Foot Surgery
- ☐ Hand Surgery
- ☐ Hip Surgery
- ☐ Knee Surgery
- ☐ Leg Surgery
- ☐ Rotator Cuff Surgery
- ☐ Shoulder Surgery

Respiratory
- ☐ Lung Surgery

Skin
- ☐ Basal Cell Carcinoma
- ☐ Melanoma
- ☐ Squamous Cell Carcinoma

Other: ____

FAMILY HISTORY

Please SELECT and indicate which family member has/had any of the following:

☐ Mother ☐ Father ☐ Siblings ☐ Grandmother ☐ Grandfather ☐ Uncle ☐ Aunt)

Arthritis ____________________________
Bedwetting ____________________________
Bladder Cancer ____________________________
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 ______________________________

Other: ____

Name: ____ Date: _____________________

Financial Responsibility Policy

Patients are responsible for payment, co-payments and deductibles at time of service. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts. In the event our office is not contacted within 30 days of you receiving our last billing statement your account will be turned over to our collection agency.

In addition, I assign directly to **Genitourinary Surgical Consultants, Jeffrey A. Snyder, MD** all surgical and/or medical benefits, if any, otherwise payable to me for services rendered.

I also verify that all the information contained on these information sheets is true and correct, to the best of my knowledge and belief. I authorize **Genitourinary Surgical Consultants, Jeffrey A. Snyder,** to release my complete records to my insurance company in order to process my claim and for any other physicians or medical facilities that may be pertinent and necessary to care and treatment.

PRINT NAME: ___________________________________ DATE: ______________________

SIGNATURE:

____