BLUERIDGE UROGYNECOLOGY, INC
DR. JAMES DAUCHER

Patient Registration Form

PATIENT INFORMATION

Patient Name: Last: ____________________ First: ____________________ Middle: ____________________

Address: ____________________________________ City:____________________ Zip: ____________

Sex (Please Circle): Male Female

Title (Please Circle): Dr. Mr. Mrs. Ms.

Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Birth Date: ___ ___ / ___ ___ / ___ ___ ___ ___

Marital Status: ____________________

Home Phone: (______) __________- ____________

Work Phone:(______) __________- ____________

Employer/Address: __________________________________ City: ____________________ Zip: __________

Emergency Contact/
Relationship: ______________________________ Phone Number: (______) _______ - _______

RESPONSIBLE PARTY

Email: ____

Guarantor's Name: __________________________________ Phone Number: (______) _______ - _______

Address: ________________________________ City: ________________ State: _______ Zip: __________
(If different from patient)

Patient Relation to Guarantor: ____________________________ Guarantor Employer: ____________________

Employer Address: ____

City: ______________________________________ State: __________ Zip: ______________

Guarantor Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

PRIMARY INSURANCE

Name of Insurance: __________________________________ Policy Holder: ____________________

ID Number: _______________________________________ Group Number: ____________________

SECONDARY INSURANCE

Name of Insurance: __________________________________ Policy Holder: ____________________

ID Number: _______________________________________ Group Number: ____________________

I hereby authorize Blue Ridge Urogynecology, Inc., to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Blue Ridge Urogynecology, Inc., of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's Signature (or Responsible Party) ____________________________________ Date: ______________

CANCELLATION AND NO-SHOW POLICY

We understand situations arise in which you must cancel your appointment. It is therefore requested if you must cancel your appointment, you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. Cancellations made less than 24 hours' notice, we are unable to offer that slot to other people.

Office appointments cancelled with less than 24 hours notification will be subject to a $45.00 cancellation fee. Procedure cancellations require 5 – 7 business days' notice, without notification they may be subject to a $150.00 cancellation fee.

- The Cancellation fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.
- We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.
- Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department (540-904-2845).

Please sign that you have read, understand and agree to this cancellation and No-Show Policy.

______________________________	______________________________
Patient Name (Please Print)	Date of Birth

______________________________	______________________________
Signature of Patient or Patient Representative	Today's Date

Blue Ridge Urogynecology

JAMES A. DAUCHER MD, FACOG

Dear Valued Patients:

Beginning January 1, 2018, Blue Ridge Urogynecology will be adopting a new payment policy.

No patient with a balance in an excess of $100.00 will be seen until payment is received or a payment plan is established.

There will be a 30% finance charge added to the payment plan and it will be applied on each new balance incurred.

Care Credit offers interest free rates for 6, 12, or 18 months if paid in full for a minimum balance of $200.00. We will be happy to help you enroll in this program.

This new policy will help patient's stay in control of their balances.

By signing below the patient agrees to the payment policy established by Blue Ridge Urogynecology and will abide by the payment plan set up for them.

______________________________ Signature

_______________ Date

Blue Ridge Urogynecology

3800 Electric Rdste 405
Roanoke, VA 24018-4549
(540) 904-2845

Our office is pleased to provide you with online access to your health information through our secure Patient Portal. Please visit the web address below to create your account.

http://www.blueridgeurogynecology.com/

This page is for you to keep

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I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's Signature (or Responsible Party) ____________________ Date ____________

Printed Name of Patient ____________________ Relationship to Patient ____________

I request and authorize Blue Ridge Urogynecology, Inc. to disclose protected health care information to the individual(s) listed below.

Name: ____________________ Contact #: ____________

Name: ____________________ Contact #: ____________

Name: ____________________ Contact #: ____________

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Patient's Signature (or Responsible Party) ____________________ Date ____________

Printed Name of Patient ____________________ Relationship to Patient ____________

I hereby consent to Blue Ridge Urogynecology, Inc. using or disclosing my protected health information for providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Blue Ridge Urogynecology, Inc. using or disclosing my protected health information for treatment activities provided by another provider or entity. I further consent to the disclosure of my protected health information for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Patient's Signature (or Responsible Party) ____________________ Date ____________

Printed Name of Patient ____________________ Relationship to Patient ____________

Blue Ridge Urogynecology

As a new patient we ask that you review and complete this questionnaire prior to arriving at the clinic so that we can better understand your health history. Completing this questionnaire will help us be better prepared to address your particular health needs. We look forward to meeting you.

Date: ____________________________________

Name: ____________________________________ Age: ____________

Address: ____________________________________ Birthdate: ____________

____

____

Telephone numbers

Home: _______________ Mobile: _______________ Work: _______________

Which telephone numbers may be call you at? Home Mobile Work

Which telephone numbers may we leave messages at? Home Mobile Work

Which **pharmacy** would you like us to call in or fax prescriptions to?

____

Provider who **referred** you:	Your **Primary Care Provider**:
Name_______________________	Name_______________________
Address_____________________	Address_____________________
City__________State____Zip Code______	City__________State____Zip Code______
Phone number:________________	Phone number:________________
Fax number:__________________	Fax number:__________________

Your **Cardiologist**:	Please list the names and addresses of <u>any other doctor</u> you would like us to communicate with:
Name_______________________	Name_______________________
Address_____________________	Address_____________________
City__________State____Zip Code______	City__________State____Zip Code______
Phone number:________________	Phone number:________________
Fax number:__________________	Fax number:__________________

MD Signature:______________________________ Date: ________________

What is the **reason for you visit:**

____

____

____

ALLERGIES

List the things you are **allergic** to. Include medications, food, and environmental allergies.

____ ☐ I do not have any allergies

Have you ever used any medicines to help control your bladder or bowels?

____ ☐ I have not used medications

MEDICATIONS: Please list all your current medications (include herbal and non-prescription medications):

Medicine	Dose	Medicine	Dose
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________

MD Signature:______________________________ Date: ________________

FAMILY HISTORY

Please note if anyone in your family has a history of any of these diseases:

			Family Member(s) Maternal Paternal
Breast Cancer	☐ Yes	☐ No	______________________
Ovarian Cancer	☐ Yes	☐ No	______________________
Other Cancer	☐ Yes	☐ No	______________________
Heart Disease	☐ Yes	☐ No	______________________
Diabetes	☐ Yes	☐ No	______________________
High blood pressure	☐ Yes	☐ No	______________________
Osteoporosis	☐ Yes	☐ No	______________________
Urinary incontinence	☐ Yes	☐ No	______________________

Please answer the following questions about **URINATION:**

How frequently do you urinate during the day?	Every ____ hours	
How many times do you get up at night to urinate?	times	
Do you ever wet the bed?	☐ Yes	☐ No
Do you completely empty your bladder when you void?	☐ Yes	☐ No
Do you have trouble starting your stream of urine?	☐ Yes	☐ No
Do you notice any change in your stream of urine?	☐ Yes	☐ No
Do you ever dribble urine?	☐ Yes	☐ No
Do you need to wear pads for protection from urine leakage?	☐ Yes	☐ No
Have you had 3 or more urinary tract infections in the past year?	☐ Yes	☐ No

On an average day how much do you drink? List below.

Type of Fluid	Amount	Type of Fluid	Amount
Example: decaf coffee	*2 8oz cups*		

MD Signature: ______________________________ Date: ________________

Please circle your **best response** to the following questions:

Does coughing gently cause you to lose urine?	Never	Rarely	Sometimes	Often
Does coughing hard cause you to lose urine?	Never	Rarely	Sometimes	Often
Does sneezing cause you to lose urine?	Never	Rarely	Sometimes	Often
Does lifting things cause you to lose urine?	Never	Rarely	Sometimes	Often
Does bending cause you to lose urine?	Never	Rarely	Sometimes	Often
Does laughing cause you to lose urine?	Never	Rarely	Sometimes	Often
Does walking briskly or jogging cause you to lose urine?	Never	Rarely	Sometimes	Often
Does straining, if you are constipated, cause you to lose urine?	Never	Rarely	Sometimes	Often
Does getting up from a sitting position cause you to lose urine?	Never	Rarely	Sometimes	Often
Some women receive very little warning but suddenly find that they are losing or about to lose urine beyond their control. How often does this happen to you?	Never	Rarely	Sometimes	Often
If you can't find a toilet or find that the toilet is occupied, and you have an urge to urinate, how often do you end up losing urine or wetting yourself?	Never	Rarely	Sometimes	Often
Do you lose urine when you suddenly have the feeling that your bladder is very full?	Never	Rarely	Sometimes	Often
Does washing your hands cause you to lose urine?	Never	Rarely	Sometimes	Often
Does cold weather cause you to lose urine?	Never	Rarely	Sometimes	Often
Does drinking cold beverages cause you to lose urine?	Never	Rarely	Sometimes	Often

Please answer the following questions about your **BOWELS:**

Do you feel you need to strain hard to have a bowel movement?	☐ Yes	☐ No
Do you feel you completely empty your bowels at the end of a bowel movement?	☐ Yes	☐ No
Do you experience a strong sense of urgency and have to rush to the bathroom to have a bowel movement?	☐ Yes	☐ No
Do you ever accidentally lose stool?	☐ Yes	☐ No
Do you ever accidentally loose gas from the rectum?	☐ Yes	☐ No
Do you need to wear pads for protection from leakage of **stool**?	☐ Yes	☐ No

MD Signature:______________________________ Date: ________________

DAILY ACTIVITIES

What kind of work do you do: ______________________

Are you currently employed? ☐ Yes ☐ No

Who is your main support person (partner, spouse, friend): ______________________

Do you consider yourself healthy: ☐ Yes ☐ No

Are you able to take care of yourself? ☐ Yes ☐ No

Do you currently smoke: ☐ Yes ☐ No

Have you ever smoked: ☐ Yes ☐ No

How many packs a day: ____________

Tobacco - years of use? ____________

Alcohol intake: None, Occasional, Moderate, Heavy

Caffeine intake: None, Occasional, Moderate, Heavy

PAST SURGICAL HISTORY: Please list the surgeries you have had:

Operation	Date	Surgeon	Hospital

MD Signature: ______________________ Date: ____________

Please answer the following questions about your **OBSTETRICAL AND GYNECOLOGIC HISTORY**

How many times have you been pregnant?	________ Times	
How many children did you deliver?	________________	
Of these how many were delivered:	_________Vaginally	_________By C-Section
How big was your biggest baby?	______ lbs _____ oz	
What was your age at each delivery?	_________________	

Did you have any problems with any of your deliveries?	☐ Yes	☐ No
Have you experienced menopause?	☐ Yes – please answer the questions below:	☐ No – please answer the questions below:
	How old were you when you went through menopause? _______ years old	Date of your Last Menstrual Period _____________
	Do you take hormone replacement? ☐ Yes ☐ No	Periods come every _______ days and last _______ days
	If yes, list the type _________	Do you have problems with your periods? ☐ Yes ☐ No
	How long have you taken hormone replacement? __________ years	Do you use Birth Control? ☐ Yes ☐ No If yes list method ____________

Are you sexually active?	☐ Yes	☐ No	
Is sexual intercourse painful for you?	☐ Yes	☐ No	
Do you leak urine during intercourse?	☐ Yes	☐ No	
In your life, have you ever been sexually or physically abused?	☐ Yes	☐ No	
Have you had any sexually transmitted infections?	☐ Yes	☐ No	
Have you ever had an abnormal Pap smear?	☐ Yes	☐ No	Date of last Pap smear _____________

MD Signature:________________________________ Date: _________________

Have you had an abnormal mammogram?	☐ Yes	☐ No	Date of last mammogram ____________
Have you ever had an abnormal colon screen?	☐ Yes	☐ No	Date of last colon screening (colonoscopy or sigmoidoscopy) ______________
Have you ever had an abnormal bone density scan?	☐ Yes	☐ No	Date of last bone density scan ______________
Have you ever had pelvic radiation for any reason?	☐ Yes	☐ No	

Please answer these questions about your **MEDICAL HISTORY**

Check all appropriate boxes.

☐ Anemia	☐ Diabetes	☐ Osteoporosis	☐ Endometriosis
☐ Arthritis	☐ Diverticulitis	☐ Parkinson's Disease	☐ Fibromyalgia
☐ Aspirin use	☐ Emphysema	☐ Pneumonia	☐ GI Problems
☐ Asthma	☐ Glaucoma	☐ Stroke	☐ Headaches
☐ Back injury	☐ Heart attack	☐ Thyroid disease	☐ Hepatitis
☐ Bleeding problem	☐ Heart disease	☐ Tuberculosis	☐ High Cholesterol
☐ Blood clot problem	☐ Heart murmur	☐ Ulcers	☐ Kidney or Bladder Problems
☐ Bowel Disease	☐ Hypertension	☐ Anesthesia Complications	☐ Ovarian Cancer
☐ Cancer	☐ Kidney disease	☐ Birth defects or Inherited Disease	☐ Thrombophilia
☐ Chronic Steroid Use	☐ Multiple Sclerosis	☐ Depression	☐ Varicosities

Please tell us more about anything that was checked above, or about any other problems:

____

____

____

MD Signature:______________________________ Date: ________________

Review of Systems

Do you have any of the following **currently or today**?

Constitutional
____ Fatigue
____Weight loss (____ lbs)
____ Weight gain (____ lbs)
____ Fever

Skin
____ Abnormal mole
____ Rash

Eyes
____ Irritation
____ Vision changes

Ear, nose and throat
____ Hearing problems
____ Ear pain
____ Sinus problems
____ Sore throat
____ Snoring
____ Dry mouth
____ Mouth ulcer

Respiratory
____ Shortness of breath
____ Chronic cough
____ Sputum production
____ Coughing up blood
____ Wheezing

Cardiovascular
____ Chest pain
____ Rapid or irregular heartbeat
____ Shortness of breath when lying down

Gastrointestinal
____ Heartburn
____ Difficulty swallowing
____ Nausea
____ Vomiting
____ Abdominal pain
____ Bowel movement changes
____ Diarrhea
____ Constipation
____ Rectal Bleeding

Genitourinary
____ Blood in urine
____ Abnormal vaginal bleeding
____ Flank pain
____ Trouble urinating
____ Pain with urination
____ Frequent urination
____ Strong urgency to urinate
____ Incontinence
____ Rash
____ Lesion
____ Discharge
____ Vaginal odor
____ Vaginal itching
____ Bulge or pressure in the vagina (Prolapse)

Endocrine
____ Irritability
____ Tension/ anxiety
____ Depressed mood
____ Breast pain/tenderness
____ Bloating
____ Painful periods
____ Hot flashes
____ Night sweats
____ Vaginal dryness
____ Impaired memory
____ Impaired concentration
____ Decreased sex drive
____ Orgasmic dysfunction
____ Painful Intercourse
____ Vaginismus

Musculoskeletal
____ Muscle aches
____ Muscle weakness
____ Muscle or joint pain
____ Back pain

Neurological
____ Headaches
____ Dizziness
____ Loss of consciousness
____ Weakness
____ Numbness
____ Seizures

Psychiatric
____ Depression
____ Alcoholism
____ Sleep disturbances

Hematologic/Lymphatic
____ Swollen glands
____ Easy bruising
____ Excessive bleeding

Allergy/Immunologic
____ Runny Nose
____ Itching
____ Hives
____ Frequent sneezing

MD Signature:______________________________ Date: ________________