☐ Michael Bagg. MD
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Rio Grande Urology

www.rgu.us.com

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☐ Arlette Camacho, FNP-BC
☐ Belen Terrazas, CPNP
☐ Rosella Vialpando, CNP

REGISTRATION FORM

PATIENT INFORMATION

Last Name: _____ First Name_____ MI: _____
Address: _____ Apt No.: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell : _____ **Email**: _____
Date of Birth: _____ Sex: [ ] Male [ ] Female SSN:_____
Marital Status *(If applicable)*: ☐Single ☐Married ☐Widowed ☐Divorced
Race: ☐ American Indian/Alaskan Native ☐Asian ☐ Black/African American ☐Hispanic/Latino ☐White ☐Other:_____
Employer: _____ Occupation: _____
Address: _____ City_____State_____Zip Code_____
Referred by: _____Phone: ( ) _____
Are there any special needs for this patient: [ ] No [ ] Yes *If yes, please explain*_____
If Patient is a Minor, please complete the following:
Parent/Legal Guardian: _____ Date of Birth: _____ SSN: _____

If available, **Pharmacy Name**: _____Phone: ( ) _____
(If a prescription is made, we will be able to call in your prescription to the Pharmacy of your choice)

BILLING PARTY INFORMATION *(If different from above)*

Last Name: _____ First Name_____ MI: _____
Address: _____ Apt No.: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell: _____ **Alternate:** _____
Date of Birth: _____ Sex: [ ] Male [ ] Female SSN:_____
Relationship to Patient: _____
Employer: _____ Occupation: _____
Address: _____City_____State_____Zip Code_____

INSURANCE INFORMATION

All HMO Policies require a referral number. If you do not have a referral, payment will be due when services are rendered.
Primary Carrier: _____ Group No.: _____
Claims Address: _____ [ ] HMO [ ] PPO
Member Number: _____ Referral No.: _____
Secondary Carrier: _____ Group No.: _____
Member Number: _____ Referral No.: _____

EMERGENCY CONTACT

Last Name: _____ First Name_____ MI: _____
Home Phone: _____ Cell: _____ Alternate: _____
Relationship to Patient: _____

*******Assignment of Benefits and Release of Information*******

May we release medical information to your spouse or family member? [ ] Yes [ ] No
I hereby authorize my insurance carrier to pay directly to Rio Grande Urology, P.A., all benefits due to me as provided for in my contract for medical services rendered. I understand that regardless of my insurance coverage, I am personally responsible for any debts incurred by me and will pay for all charges in excess of whatever sums are paid for by my insurance company.

Signature: _____ Date: _____

PATIENT HISTORY FORM

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

DATE ____/____/____ DATE OF LAST PHYSICAL EXAM ____/____/____

LAST NAME _____ FIRST NAME _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____

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

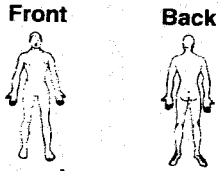
Abdomen Back Leg

Other _____

_____

_____

Front Back



On a Scale of 1-10, with being 10 the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem worse?

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 is always there

Other _____

Is anything else occuring 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)

#Answers	Level of Service
1 - 3	1 - 2
4 +	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

_____ _____ _____

_____ _____ _____

List any personal past illnesses and/or surgeries and when they occured. 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 (If yes, list all)

_____

_____

Are you on a special diet? Y N (If yes, please explain)

_____

Do you have allergies? Y N (If yes, please explain)

_____

Physician use only: (Comments/Notes)

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

Review of Systems

Do you now or have you had a problem related to the following systems? Circle **Yes** or **No**.

Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	**Yes**	**No**
Chills	**Yes**	**No**
Headache	**Yes**	**No**

Other _____

Eyes

Blurred Vision	**Yes**	**No**
Double Vision	**Yes**	**No**
Pain	**Yes**	**No**

Other _____

Allergic/Immunologic

Hay Fever	**Yes**	**No**
Drug Allergies	**Yes**	**No**

Other _____

Neurological

Tremors	**Yes**	**No**
Dizzy spells	**Yes**	**No**
Numbness/Tingling	**Yes**	**No**

Other _____

Endocrine

Excessive thirst	**Yes**	**No**
Too Hot/Cold	**Yes**	**No**
Tired/Sluggish	**Yes**	**No**

Other _____

Gastrointestinal

Abdominal pain	**Yes**	**No**
Nausea/Vomiting	**Yes**	**No**
Indigestion/Heartburn	**Yes**	**No**

Other _____

Cardiovascular

Chest pain	**Yes**	**No**
Varicose Veins	**Yes**	**No**
High Blood Pressure	**Yes**	**No**

Other _____

Integumentary

Skin rash	**Yes**	**No**
Boils	**Yes**	**No**
Persistent itch	**Yes**	**No**

Other _____

Musculoskeletal

Joint pain	**Yes**	**No**
Neck pain	**Yes**	**No**
Back pain	**Yes**	**No**

Other _____

Ear/Nose/Throat/Mouth

Ear infection	**Yes**	**No**
Sore throat	**Yes**	**No**
Sinus problems	**Yes**	**No**

Other _____

Genitourinary

Urine retention	**Yes**	**No**
Painful urination	**Yes**	**No**
Urinary frequently	**Yes**	**No**

Other _____

Respiratory

Wheezing	**Yes**	**No**
Frequent cough	**Yes**	**No**
Short of breath	**Yes**	**No**

Other _____

Hematology/Lymphatic

Swollen glands	**Yes**	**No**
Blood clotting problem	**Yes**	**No**

Other _____

Psychologic

Are you generally satisfied with your life?	**Yes**	**No**
Do you feel depressed?	**Yes**	**No**
Have you considered suicide?	**Yes**	**No**

Other _____

Physician use only: (Comments/Notes)

#Answer	Level of service
0-1	1 or 2
2 - 9	3
10+	4 or 5

Phvsician: _____ Date: _____

Rio Grande Urology

MEDICATION LIST

Lista de Medicamentos

- ☐ Michael Bagg. MD
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- ☐ Arlette Camacho, FNP-BC
- ☐ Belen Terrazas, CPNP
- ☐ Rosella Vialpando, CNP

Date/*Fecha*: _____

Patient Name/*Nombre del Paciente*:

_____

Date of Birth/*Fecha de Nacimiento*:

_____

Allergies/*Alergias*:

_____

Medications/Medicamentos:

Please complete prior to your visit with your physician/*Por favor complete antes de su visita con su medico.*

Thank you/*Gracias*

RGU
RIO GRANDE UROLOGY

Patient Portal…a new beginning!

MAY 1, 2014

RGU will implement Healthronic's Patient Portal system with our Electronic Medical Records (EMR) during the month of May 2014, with a secure messaging function that supports communication between patients and providers. As mandated by the Federal Government, Providers must offer patient's secure timely electronic access to their health information.

What is a Patient Portal?

The patient portal is an online tool that offers patients a secure environment to perform functions like scheduling appointments, requesting refills on medications, looking at lab results and communicating with their providers in a confidential and secure manner. Unlike traditional methods of correspondence, the patient portal allows for communication without the delay of ground mail, missed phone calls or misinterpreted voice messages. Using a secure username and password, patients are granted access to the portal via the web.

- Patients provide their e-mail address to RGU staff during an in-person clinic visit.
- A message is instantly delivered to the patient's e-mail address encouraging him or her to complete the second step of the patient portal enrollment process.

Benefits of accessing our Patient Portal

Patients can use the patient portal to:

- E-mail questions
- Request prescription refills
- Schedule appointments

Providers have the ability to:

- Send patients post-visit clinical summaries and lab results via an attachment
- Respond to patient messages in between seeing patients to complete tasks more efficiently and avoid "phone tag" with patients

Getting Patients Registered: Patient portal registration is a two-step process

- Patients provide their e-mail address to RGU staff during an in-person clinic visit, complete information below and your registration will be completed.
- Upon registration, a message is instantly delivered to the patient's e-mail address encouraging him or her to complete the second step of the patient portal enrollment process. **Please be advised your temporary password is active for 72hrs only.**

Patient Portal Registration: Please complete and turn in to any staff member.

Date: _____

Name: _____ Telephone No.: _____

Email address: _____

Attention staff: Please turn in completed forms to Office Manager.