Welcome to our practice. In order to facilitate your office visit, please complete the enclosed forms and bring them to your appointment. By doing this prior to your office visit, you will help us stay on time and make your visit as efficient as possible.

Please bring the following to your appointment:

- Completed forms (please use a pen and sign all forms)
- Insurance card & driver’s license or photo ID
- Insurance co-pay for specialist (amount usually found on your insurance card)

Your Appointment details:  
Appt. date: ___________  
Check-in Time: ___________

Provider:  
☐ Karl R Westenfelder, MD  
☐ Garrick R Simmons, MD  
☐ Kevin M Kronner, MD  
☐ Christopher G Wicher, MD  
☐ Richard Wiesemann PA-C  
☐ Whitney C Martin PA-C

- Urine specimens are requested from most patients so please come prepared to leave a specimen.

If you have questions please call our office at the 728-3366. Our hours are 8 a.m. to 5 p.m., Monday through Friday, or look on our website for more information.  www.fivevalleysurology.com

Our Location: 2875 Tina Avenue, Suite 101 Missoula, MT 59808 Phone: (406)728-3366 Fax: (406-728-0651)
We appreciate the opportunity to serve you and pledge to provide you our best medical care, with compassion, in a safe environment. In order to make our relationship with you the best it can possibly be, please be familiar with the following policies:

**Administrative Policies**

- We promise to inform you at check-in if your doctor is running late or has been called to surgery.
- Many appointments require collection of a urine sample, please check with the front desk upon arrival before going to the bathroom.
- To respect other patients, we ask that cell phones be turned on vibrate mode while in our office.
- In-office procedures such as vasectomy require extra supplies. Cancellation of a vasectomy within 24 hours of appointment will result in a $75.00 sterile tray fee. Canceling Urodynamics within 72 hours will result in a $100.00 fee. By scheduling an in-office procedure you agree to these terms.
- Missing or no-showing your appointment creates an undue burden and increases the cost of care to other patients. Should you miss three appointments without notice, you will be dismissed from this practice.
- We promise to treat you with respect & dignity in a professional and caring manner. In return we expect you to refrain from using verbally abusive language, threatening any employee or provider, or otherwise hostile behavior. Using such is cause for immediate termination from this practice.
- When you are placed in an exam room, we will partially shut the door to protect everyone's privacy.

**Insurance & Billing Policies**

- If you do not have insurance or choose not to file your visit with your insurance, a minimum payment of $100 at time of service is required. The remaining balance for services received will be addressed in our billing statement.
- Your health insurance policy is an agreement between you and your insurance carrier. You are responsible for understanding your own coverage. Your insurance company makes the determination of your eligibility. You authorize your benefits to be transferred directly to the rendering provider and acknowledge you are financially responsible for paying any co-insurance amounts. You agree to pay for services rendered within the limits of this care provisions policy.
- Disability, FMLA, and other form completion requests will be processed after a form fee of $25.00 is received.
- Many insurance companies have lists of approved drugs they cover. Your provider will prescribe the medication they feel will best address your needs. We will do our best to respond to prior authorization requests from your insurance company, but this process may delay your prescription. You are responsible for contacting your insurance provider with any questions or requests concerning approved medications.

By signing below you agree to the terms of service provided herein.
# Registration Form

**FIVE VALLEYS UROLOGY**

**rev. 11/2015**

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>NAME (Last, First, Middle)</th>
<th>AGE</th>
<th>DOB</th>
<th>SEX</th>
<th>SOC. SEC. #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>BILLING ADDRESS</th>
<th>PHYSICAL ADDRESS (If Applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CITY, STATE, ZIP</td>
<td>CITY, STATE, ZIP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOME PHONE</th>
<th>CELL PHONE</th>
<th>MARITAL STATUS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>EMAIL ADDRESS</th>
<th>SPouse/PARTNER NAME</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>OCCUPATION</th>
<th>EMERGENCY CONTACT</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>EMPLOYER</th>
<th>EMERGENCY PHONE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>WORK PHONE</th>
<th>EMERGENCY CONTACT RELATIONSHIP TO PATIENT</th>
</tr>
</thead>
</table>

## PARENT/GUARDIAN INFORMATION IF PATIENT IS A MINOR

<table>
<thead>
<tr>
<th>FATHER NAME</th>
<th>SSN#</th>
<th>DOB</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ADDRESS (IF DIFFERENT FROM PATIENT)</th>
<th>CITY, STATE, ZIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HOME PHONE</th>
<th>CELL PHONE</th>
<th>EMPLOYER/WORK PHONE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MOTHER NAME</th>
<th>SSN#</th>
<th>DOB</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ADDRESS (IF DIFFERENT FROM PATIENT)</th>
<th>CITY, STATE, ZIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HOME PHONE</th>
<th>CELL PHONE</th>
<th>EMPLOYER/WORK PHONE</th>
</tr>
</thead>
</table>

## HEALTH INSURANCE INFORMATION (PLEASE PRESENT YOUR CARD TO FRONT DESK AT CHECK IN)

CO-PAYS OR SELF-PAY DEPOSITS ARE DUE AT TIME OF SERVICE. WE REQUIRE 24 HR NOTIFICATION OF CANCELLATIONS OR REQUESTS TO RESCHEDULE. WE CHARGE NO SHOW FEES FOR MOST APPOINTMENT TYPES.

### PRIMARY INSURANCE

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>GROUP #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CITY, STATE, ZIP</th>
<th>GROUP #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME OF INSURED</th>
<th>SSN#</th>
<th>DOB</th>
</tr>
</thead>
</table>

### SECONDARY INSURANCE

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>GROUP #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CITY, STATE, ZIP</th>
<th>GROUP #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME OF INSURED</th>
<th>SSN#</th>
<th>DOB</th>
</tr>
</thead>
</table>

SOME INSURANCE COMPANIES REQUIRE LABS, IMAGING, TEST, PROCEDURES, AND/OR SURGERIES TO BE PERFORMED AT SPECIFIC FACILITIES AND WILL DENY PAYMENT OTHERWISE. PLEASE INFORM OUR OFFICE IF YOUR POLICY HAS SUCH LIMITATIONS. YOU MUST NOTIFY OUR OFFICE IF YOUR INSURANCE COMPANY REQUIRES PRE-AUTHORIZATION FOR SERVICES.

## ASSIGNMENT AND RELEASE OF INFORMATION

To the best of my knowledge, all of this is true and complete. I authorize payment of insurance benefits directly to Five Valleys Urology. I understand that I am responsible to pay for all services rendered to me. I am willing to make specific arrangements to pay the portion that is not covered by insurance. I authorize Five Valleys Urology to mutually exchange medical information with my referring physician(s) and/or associates. To the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of my medical information to my insurance carrier and/or any attorney assigned.

## CONSENT TO TREAT

I hereby request and consent to treatment and services reasonable and proper by today's standards provided by a provider of Five Valleys Urology and any employee acting under my providers orders.

SIGNATURE OF RESPONSIBLE PARTY: ___________________________ DATE: ___________________________
I understand that protected health information (PHI) may be used and disclosed to perform treatment, payment and/or healthcare operations. I acknowledge I've been given the opportunity to read and review a complete copy of the Five Valleys Urology Privacy Notice with a complete description of such uses and disclosures. I understand that protected health information (PHI) may be used and disclosed to perform treatment, payment, and healthcare operations. I also understand that I have the right to review and receive a copy of this notice. I understand that I may revoke this authorization at any time, in writing, as required by law; however, revocation of this authorization will not affect the disclosure based on it before the revocation took effect.

Printed Name     Signature      Date
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Additional Privacy & Communication Considerations

May we send text messages that might contain PHI? □ Yes □ No

Email: ____________________________

May we leave messages or voice mails that might contain PHI? □ Yes □ No

Tel: ____________________________ Relation: ____________________________

Is this person also authorized to discuss financial matters? □ Yes □ No

1. Designated Party:       Tel:   Relation:       Email: ____________________________

Is this person also authorized to discuss financial matters? □ Yes □ No

2. Designated Party:       Tel:   Relation:       Email: ____________________________

Is this person also authorized to discuss financial matters? □ Yes □ No

3. Designated Party:       Tel:   Relation:       Email: ____________________________

Is this person also authorized to discuss financial matters? □ Yes □ No

May we leave messages or voice mails that might contain PHI? □ Yes □ No

May we send email that might contain PHI? □ Yes □ No

email: ____________________________

May we send text messages that might contain PHI? □ Yes □ No

cell: ____________________________

Privacy & Confidentiality Notice

FIVE VALLEYS UROLOGY

(Reference Federal Register 45 C.F.R. § Part 164.506)
**UROLOGIC HISTORY FORM**

Name: ____________________________ Date of Birth: _____/_____/______

Please Circle Race: African American
American Indian
Alaskan Native
Asian
Black
Hispanic
Native Hawaiian
Other

Age: _______ Weight: _______ Height: _______ Gender: _______

Primary Doctor: ____________________________ Referring Doctor: ____________________________

Have you been seen by us in the past? Yes No If yes, when? __________ By whom? __________

Occupation: ____________________________ Do you have an Advanced Care Directive? Yes No (please bring copy)

**MEDICATIONS/ALLERGIES/IMMUNIZATIONS LIST**

**ALLERGIES:** None Codeine IVP Dye Latex Mycins Penicillin Sulfa Cipro/Levaquin

**OTHER ALLERGIES:** ________________________________________________________________

**PHARMACY NAME & ADDRESS:** ______________________________________________________

**PHARMACY PHONE & FAX:** ____________________________ MAIL ORDER? Yes No

**BLOOD THINNERS:** Aspirin Plavix Warfarin Coumadin Ibuprofen Aleve Motrin Celebrex Other: ____________________________

**IMMUNIZATIONS:** Influenza Immunization? N Y date ____________ Pneumococcal Vaccination? N Y date ____________

**Medications:** Please list all prescription & OTC medications and supplements

<table>
<thead>
<tr>
<th>Dose</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL HISTORY**

Check any past & ongoing medical problems

- Acid Reflux
- Anemia
- Angina
- Arthritis
- Asthma
- Cancer: type
- Chronic UTIs
- Congestive Heart Failure
- COPD
- Coronary Artery Disease
- Chron’s Disease
- Dementia
- Depression
- Diverticulitis
- Diabetes: # of years
- Enlarged Prostate
- Glaucoma
- Gout
- Heart Attack
- Hepatitis C
- High Blood Pressure
- High Cholesterol
- HIV
- IBS
- Kidney Disease
- Kidney Stones
- Liver Disease
- Lupus
- Migraines
- Multiple Sclerosis
- Neurologic
- Osteoarthritis
- Osteoporosis
- Parkinson’s
- Peptic Ulcer
- Peripheral Vasc. Disease
- Rheumatoid Arthritis
- Seizure Disorder
- Stroke
- Thyroid Disease

Other (please explain) ____________________________ Hearing loss? Yes No Hearing Aids? Yes No

**Rev. 10/2015**
Check if “C” for Current or “P” for Past to any urological problems below

**Gender specific – female**

- Blood in your urine
- Pregnant
- Undescended Testicles
- Urinary Tract Infection
- Trying to become pregnant
- Curvature of the penis
- Loss of urine when you cough, sneeze, or strain
- Cysts
- Varicocele
- Kidney or Bladder Stones
- Menstrual pain
- Epididymitis
- Bedwetting or daytime wetting of clothes
- Organ prolapse
- Problems with sex drive
- Skin problems in genital or groin area
- Endometrioses
- Problems with ejaculation
- Problems with orgasm
- Curvature of the penis

**Gender specific – male**

- Check any past surgical history

- **Appendectomy**
- **Bladder Suspension**
- **Prostate Surgery**
- **Back Surgery**
- **Breast Biopsy**
- **Penile Prosthesis**
- **Heart Bypass**
- **C-section**
- **Colon Surgery**
- **Hysterectomy**
- **Scrotal Area Surgery**
- **Heart Stent**
- **Hip Replacement**
- **Kidney Stones**
- **Kidney Removal**
- **Tubal Ligation**
- **Vaginal Delivery**
- **Prostatectomy**
- **Pyeloplasty**
- **Prostate Biopsy**
- **Prostatectomy**
- **Tonsillectomy**
- **Vaginal Delivery**

**Other**

- Appendectomy
- C-section
- Hip Replacement R/L
- Kidney Stones
- Knee Replacement R/L
- Knee Surgery
- Mastectomy R/L
- Heart Stent
- Heart Bypass
- Breast Biopsy
- Breast Surgery
- Ovarian Surgery
- Ovarian Cancer
- Other

**FAMILY HISTORY**

- Diabetes
- Enlarged Prostate
- High Blood Pressure
- Kidney Stones
- Kidney Failure
- Prostate Cancer
- Stroke
- Urinary Tract Infections
- Cancer: Other

**SOCIAL HISTORY**

- Cancer: Other
- Diabetes
- Enlarged Prostate
- High Blood Pressure
- Kidney Stones
- Kidney Failure
- Prostate Cancer
- Stroke
- Urinary Tract Infections
- Cancer: Other

**SURGICAL HISTORY**

- Prostatectomy
- Pyeloplasty
- Prostatectomy
- Tonsillectomy
- Vaginal Delivery
- Prostatectomy

**FAMILY HISTORY**

- Mother Living
- Father Living
- Brother
- Sister
- Grandparent
- Son
- Daughter
- Runs in Family

- Adopted

- **Diabetes**
- **Enlarged Prostate**
- **High Blood Pressure**
- **Kidney Stones**
- **Kidney Failure**
- **Prostate Cancer**
- **Stroke**
- **Urinary Tract Infections**
- **Cancer: Other**

**SURGICAL HISTORY**

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- Pyeloplasty
- Prostatectomy
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- **Urinary Tract Infections**
- **Cancer: Other**

**SURGICAL HISTORY**

- Prostatectomy
- Pyeloplasty
- Prostatectomy
- Tonsillectomy
- Vaginal Delivery
- Prostatectomy

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- **Kidney Failure**
- **Prostate Cancer**
- **Stroke**
- **Urinary Tract Infections**
- **Cancer: Other**

**SURGICAL HISTORY**

- Prostatectomy
- Pyeloplasty
- Prostatectomy
- Tonsillectomy
- Vaginal Delivery
- Prostatectomy
**CHIEF COMPLAINT & PRESENT ILLNESS**

What is the main reason for your visit today? ____________________________________________________________

<table>
<thead>
<tr>
<th>Location of the problem</th>
<th>How long does the problem last?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdomen</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Back</td>
<td>1 hour</td>
</tr>
<tr>
<td>Leg</td>
<td>It is always there</td>
</tr>
<tr>
<td>Flank</td>
<td>Other</td>
</tr>
<tr>
<td>Pelvis</td>
<td>Other</td>
</tr>
<tr>
<td>Rectum</td>
<td>Other</td>
</tr>
<tr>
<td>Bladder</td>
<td>Other</td>
</tr>
<tr>
<td>Genitalia</td>
<td>Other</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

When did you first notice the problem? 

<table>
<thead>
<tr>
<th>2 days ago</th>
<th>2 weeks ago</th>
<th>1 month ago</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other __________________________________________

Is anything else occurring at the same time? 

Yes | No

(If yes, explain) __________________________________________

Do you have Nausea | Rash | Headaches 

Yes | No | No

Other __________________________________________

Is the problem constant or variable? 

Constant | Variable | Dull then Sharp | Very sharp then leaves

Other __________________________________________

Does anything help or make the problem worse? 

Moving around | Standing Up | Lying on my side

Other __________________________________________

Does the problem interfere with your normal functions? 

Yes | No

Explain __________________________________________

What testing have you had to evaluate your urological problem? (Please circle) 

- X-Ray
- CT Scan
- Ultrasound
- MRI
- Nuclear bone scan
- Nuclear renal scan
- IVP
- Urine Specimen
- Urodynamic Testing
- Cystoscopy
- Where were tests performed? ________________

Urinary Questionnaire

- Do you leak urine? Yes | No
- If yes, is your leakage associated with the urge to urinate? Yes | No
  - If yes, do you wear protective pads / protective liners / diapers Yes | No
    #pads/day ________________
- Does your urine smell? Yes | No
- Is your urine discolored? Yes | No

Sexual Health Questionnaire

- Are you satisfied with your sexual life? Yes | No
- Do you have decreased libido/desire? Yes | No
- (Men only) Have you tried any medications for erectile dysfunction? Yes | No
- If yes, which? __________________________
- (Women only) Have you tried any treatments for vaginal tissue rejuvenation? Yes | No
- If yes, which? __________________________

Over ➡️
<table>
<thead>
<tr>
<th>Systems</th>
<th>Today's Date</th>
<th>Level of Service</th>
<th>Physician Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of Systems</td>
<td>FIVE VALLEYS UROLOGY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Constitutional Symptoms

- Explain any Current
- Integumentary
- Explain any Current
- Fever
- Skin Rash
- Chills
- Boils
- Headaches
- Persistent Itch
- Other

Eyes

- Neurological
- Blurred Vision
- Tremors
- Double Vision
- Dizzy Spells
- Pain
- Numbness/Tingling
- Other

Ear/Nose/Throat/Mouth

- Musculoskeletal
- Ear Infection
- Joint Pain
- Sore Throat
- Neck Pain
- Sinus Problems
- Back Pain
- Other

Cardiovascular

- Endocrine
- Chest Pain
- Excessive Thirst
- Varicose Veins
- Too hot/cold
- High Blood Pressure
- Other

Respiratory

- Psychologic
- Wheezing
- Frequent Cough
- Shortness of Breath
- Other

Gastrointestinal

- Abdomen Pain
- Nausea/Vomiting
- Swollen Glands
- Indigestion/Heartburn
- Blood Clotting
- Other

Genitourinary

- Reproductive - Male
- Urine Retention
- Painful Urination
- Urinary Frequency
- Other

Reproductive - Female

- Breast Lumps/Pain
- Hay Fever
- Drug Allergies
- Other

Allergic/Immunologic

- Explain if yes

Hematological/Lymphatic

- Explain if no

Psychologic

- Tired/Sleepless
- Too Much Sleep
- Excessive Thirst
- Other

Endocrine

- Back Pain
- Neck Pain
- Joint Pain
- Other

Musculoskeletal

- Numbness/Lightheadedness
- Dizzy Spells
- Tremors
- Other

Neurological

- Persistent Lich
- Boils
- Skin Rash
- Other

Inguinal Hernia

- Explain any Current

Please check any problems you have or have had in the past month.