



# UROLOGY, P.C.

5500 Pine Lake Road Lincoln, Nebraska 68516 (402) 489-8888 Fax (402) 421-1945

R.A. Crusinberry, M.D.  
D.L. Henslee, M.D.  
P.E. Howe, M.D.  
S.S. Lacy, M.D.  
C.E. Larson, M.D.  
A.J. Lepinski, M.D.  
L.A. Wiebusch, M.D.  
D.B. Wiltfong, M.D.

M.K. Fulton, APRN-C  
C.T. Bock, PA-C  
K.A. Wragge, PA-C

The physicians and staff of Urology, P.C. would like to welcome you to our facility. Please bring all completed forms with you to your appointment.

You are scheduled for an appointment regarding erectile dysfunction or a condition related. This is to inform you that **your insurance may or may not cover your services**. It is your responsibility to contact your insurance company to find out if you have coverage for this condition. Many times lab is done and prescriptions or medications are given that also may not be covered. We want you to be aware that the charges for the services provided will be your responsibility if it is deemed a non-covered benefit. Regardless of your insurance coverage, **we require a \$50 payment due at check-in for this appointment and future related appointments**. Please be prepared to make this payment or your appointment will be rescheduled. If you have further questions, please contact our billing department at 402-489-8888 option 4.

**Please arrive 15 minutes prior to your appointment time**, this will allow us to make your experience here more pleasant and efficient. It is important for us to meet your medical needs; therefore, we feel the following information is needed:

- 1) Medical information pertaining to your visit
- 2) List of your prescriptions or over-the-counter or herbal medications including doses
- 3) Lab results (urine cultures, PSA, blood work, etc.)
- 4) X-rays (actual films preferred)
- 5) Referrals or Pre-authorizations if required by your Insurance
- 6) All Insurance Cards (Medicare, Medicaid, etc.)
- 7) Photo ID (Driver's License, Military ID, etc.)

We are located on the NW corner of 56<sup>th</sup> & Pine Lake Road in Lincoln, Nebraska. If you have any further questions or concerns regarding the above information please feel free to contact us at (402) 489-8888 and we will be happy to assist you.

We look forward to caring for you.

Urology, P.C.

visit us at [www.lincolnurologypc.com](http://www.lincolnurologypc.com)



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Melissa K. Fulton, APRN  
Casey T. Bock, P.A.-C.  
Kimberley A. Wragge, P.A.-C.

## EVALUATION QUESTIONNAIRE FOR IMPOTENCY OR SEXUAL DYSFUNCTION

Your responses to the items on this questionnaire will allow us to make a preliminary decision about arrangements necessary for the proper diagnostic and treatment program.

### 1. IDENTIFICATION INFORMATION

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Occupation \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Your Doctor's Name \_\_\_\_\_

Your Doctor's Address \_\_\_\_\_  
Street City State Zip Code

Your Doctor's Telephone Number (\_\_\_\_) \_\_\_\_\_

Your Doctor's Specialty:  General Practice  Urology  Other (specify) \_\_\_\_\_

### 2. Please describe in your own words your past sexual history. Include in this description your current problem, how the problem began, and how this problem affects your life now.

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**3. Please give a brief description of your social-educational background (parents, marital status, children, social environment, etc.). Include the items that *you* feel may be important to us in assessing the potential value of this treatment or in selecting the best treatment to suit your case.**

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**\*PLEASE CHECK THE CORRECT BOX TO THE YES/ NO QUESTIONS\***

**4. CHARACTERISTICS OF ERECTION**

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| A. Do you have erections at all?   | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Are you able to get sufficient erection to make vaginal penetration?<br>___ Never ___ Rarely ___ Half the Time<br>___ Most of the Time ___ Always |                          |                          |
| C. Do you ever awaken in the morning with an erection?   | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Does the quality of your erections improve occasionally?  | <input type="checkbox"/> | <input type="checkbox"/> |

**5. CHARACTERISTICS OF PENIS**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| A. Are you concerned about the size of your penis?<br>If so, what is the problem? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| _____   |                          |                          |

**6. CHARACTERISTICS OF ORGASM OR CLIMAX**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Can you <i>now</i> have orgasms or climaxes?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how often? _____  |                          |                          |
| If so, how is orgasm achieved?   |                          |                          |
| ___ Vaginal Penetration ___ By Hand ___ Orally                         |                          |                          |
| ___ Conventional Method with Partner but without Penetration           |                          |                          |
| ___ Other (describe) _____   |                          |                          |
| B. Can you masturbate to climax?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, does the penis get hard then?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| C. How often did you have orgasms before your problem developed? _____ |                          |                          |

## 7. CHARACTERISTICS OF SEXUAL DESIRE

- A. How strong is your desire for sexual intercourse?  
\_\_\_ Poor \_\_\_ Fair \_\_\_ Strong \_\_\_ Very Strong
- B. How strong is the desire of your wife or sexual partner?  
\_\_\_ Poor \_\_\_ Fair \_\_\_ Strong \_\_\_ Very Strong
- C. How long have you been with your current partner? \_\_\_\_\_
- D. What is your partner's attitude about your possibly having an operation to treat impotence? \_\_\_\_\_  
\_\_\_\_\_

## 8. TREATMENT

- |   | YES                      | NO                       |       |       |       |       |       |       |                          |                          |
|---|--------------------------|--------------------------|-------|-------|-------|-------|-------|-------|--------------------------|--------------------------|
| A. Have you seen a doctor for treatment of your problem?<br>If so, please describe the treatment and results: _____<br>_____<br>_____   | <input type="checkbox"/> | <input type="checkbox"/> |       |       |       |       |       |       |                          |                          |
| B. Have you consulted any kind of mental health counselor (specialist, psychiatrist, psychologist, or social worker) about your problem?<br>If so, please describe when and the results. (The counselor's name and address are necessary so that we may obtain his or her report, which in some cases, is extremely helpful to us.) _____<br>_____<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> |       |       |       |       |       |       |                          |                          |
| C. Do you take any daily or weekly medication?<br>If so, list them and indicate the purpose of each:<br><table border="1"><thead><tr><th><u>Medication</u></th><th><u>Purpose</u></th></tr></thead><tbody><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr></tbody></table>                   | <u>Medication</u>        | <u>Purpose</u>           | _____ | _____ | _____ | _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>Medication</u>   | <u>Purpose</u>           |                          |       |       |       |       |       |       |                          |                          |
| _____   | _____                    |                          |       |       |       |       |       |       |                          |                          |
| _____   | _____                    |                          |       |       |       |       |       |       |                          |                          |
| _____   | _____                    |                          |       |       |       |       |       |       |                          |                          |
| D. Have you ever had a heart attack?<br>If so, describe the severity and results: _____<br>_____  | <input type="checkbox"/> | <input type="checkbox"/> |       |       |       |       |       |       |                          |                          |
| E. Have you had any major surgery?<br>If so, describe and indicate the results: _____<br>_____  | <input type="checkbox"/> | <input type="checkbox"/> |       |       |       |       |       |       |                          |                          |
| F. Have you had any serious injury from an accident?<br>If so, describe it: _____<br>_____  | <input type="checkbox"/> | <input type="checkbox"/> |       |       |       |       |       |       |                          |                          |

**9. If there are any questions that you cannot answer or that you feel need further discussion for clarification, at what phone number would you want to be reached?**

	<b>Residence</b>	<b>Business</b>
Telephone Number	(____) _____	(____) _____
Time To Call	_____	_____
Other Instructions:	_____	
	_____	

**10. This space is provided for any further information that you feel is pertinent and might have been overlooked:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**11. Are you aware of the use of prosthetic implants for treatment of impotence? If so, where did you learn of this? How do you feel about this possibility?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

## SECTION 2

Please check the box for the following YES/ NO questions:

	YES	NO
1 Do you have blurred vision?		
2 Has your eyesight often blacked out completely?		
3 Do you have loss of peripheral vision?		
4 Do you sometimes have severe soaking sweats at night?		
5 Have you ever had a chronic chest condition?		
6 Have you ever had T.B. (Tuberculosis)?		
7 Did you ever live with anyone who had T.B.?		
8 Has a doctor ever said your blood pressure was too high?		
9 Has a doctor ever said your blood pressure was too low?		
10 Do you have pains in the heart or chest?		
11 Are you often bothered by thumping of the heart?		
12 Does your heart often race like mad?		
13 Do you often have difficulty in breathing?		
14 Do you get out of breath long before anyone else?		
15 Do you sometimes get out of breath just sitting still?		
16 Are your ankles badly swollen?		
17 Do cold hands or feet trouble you even in hot weather?		
18 Do you suffer from frequent cramps in your legs?		
19 Has a doctor ever said you had heart trouble?		
20 Does heart trouble run in your family?		
21 Are you troubled by bleeding gums?		
22 Is your appetite poor?		
23 Have you ever had jaundice (yellow eyes and skin)?		
24 Are you troubled with a serious bodily disability or deformity?		
25 Have you noted less hair on face, pubic area, underarms, or chest?		
26 Do cuts in your skin usually stay open a long time?		
27 Do you sweat a great deal even in cold weather?		
28 Does your skin often break out in a rash?		
29 Are you often troubled with boils?		
30 Do you suffer badly from frequent severe headaches?		
31 Does pressure or pain in the head often make life miserable?		
32 Are headaches common in your family?		
33 Do you often have spells of severe dizziness?		
34 Do you frequently feel faint?		
35 Do you have constant numbness or tingling in any part of your body?		
36 Was any part of your body ever paralyzed?		
37 Were you ever knocked unconscious?		
38 Have you at times had a twitching of the face, head, shoulders, or other parts of the body?		

39 Did you ever have a fit or convulsion (epilepsy)?		
40 Are you a bed wetter?		
41 Were you a bed wetter between the ages of 8 and 14?		
42 Have you noted less hair on your legs?		
43 Have you ever had anything seriously wrong with your genitals (privates)?		
44 Are your genitals often painful or sore?		
45 Have you ever had treatment for your genitals?		
46 Have you ever passed blood while urinating (passing urine)?		
47 Do you have trouble starting your stream when urinating?		
48 Do you have to get up every night and urinate?		
49 During the day, do you usually have to urinate frequently?		
50 Do you often have severe burning pain when you urinate?		
51 Do you sometimes lose control of your bladder?		
52 Has a doctor ever said you had a kidney or bladder disease?		
53 Do you often get spells of complete exhaustion or fatigue?		
54 Do you usually get up tired and exhausted in the morning?		
55 Does every little effort wear you out?		
56 Do you suffer from severe nervous exhaustion?		
57 Are you frequently ill?		
58 Are you always in poor health?		
59 Are you considered a sickly person?		
60 Do you wear yourself out worrying about your health?		
61 Are you always ill and unhappy?		
62 Are you constantly made miserable by poor health?		
63 Did you ever have scarlet fever?		
64 As a child, did you have rheumatic fever, growing pains, or twitching of the limbs?		
65 Were you ever treated for severe anemia (thin blood)?		
66 Were you ever treated for "bad blood" (venereal disease)?		
67 Do you have diabetes (sugar disease)?		
68 Did a doctor ever say you had a goiter (in your neck)?		
69 Did a doctor ever treat you for tumor or cancer?		
70 Do you suffer from any chronic disease?		
71 Are you definitely overweight?		
72 Are you definitely underweight?		
73 Did a doctor ever say you had varicose (swollen) veins in your legs?		
74 Did you ever have a serious operation?		
75 Did you ever have a serious injury?		
76 Do you usually have great difficulty in falling asleep or staying asleep?		
77 Do you smoke more than 20 cigarettes a day?		
78 Do you drink more than six cups of coffee or tea a day?		
79 Do you usually take two or more alcoholic drinks a day?		

**YES NO**

80 Do you usually feel unhappy and depressed?		
81 Does worrying continually get you down?		
82 Are you considered a nervous person?		
83 Did you ever have a nervous breakdown?		
84 Were you ever a patient in a mental hospital (for your nerves)?		
85 Have you noticed a tremor, shakiness, clumsiness, or awkwardness of your hands or feet?		
86 Have you had polio?		
87 Do you have numbness of your ears or lips?		
88 Have you had a herniated intervertebral disc (slipped disc in the back)?		
89 Do you have neuralgia or neuritis?		
90 Do you have shooting pains in your arms or legs?		
91 Do you have weakness of any muscles?		
92 Do you have pain in your back and/or buttocks?		

**PATIENT REGISTRATION FORM FOR  
UROLOGY P.C. & UROLOGY SURGICAL CENTER**

<b>Referring Physician:</b>	<b>Today's Date</b>
<b>Primary Care Physician:</b>	

**PATIENT INFORMATION**

Patient's Last Name:		First:	M.I.:	Birth Date:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Is this the patient's legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what is the patient's legal name?			Former name(s):
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated				SSN:	
Street Address:			Billing Address (if different):		
City	State	Zip Code	Home Phone: ( ) ( )		Cell Phone: ( ) ( )
Current Work Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Not Employed			Occupation:		
Employer Name		Address:		Work Phone & Ext.: ( ) ( )	
Current School Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			Name of School:		

**PRIMARY CONTACT PERSON (SPOUSE, PARENT, SIGNIFICANT OTHER, ETC.)**

Name:	SSN:	DOB:	Relationship:
Address:		Employer:	
Home Phone: ( ) ( )	Work Phone: ( ) ( )	Cell Phone: ( ) ( )	

**SECONDARY CONTACT PERSON (PARENT, CHILD, NEXT OF KIN, ETC.)**

Name:	Relationship:
Address:	
Employer:	
Home Phone: ( ) ( )	Work Phone: ( ) ( )
Cell Phone: ( ) ( )	

**INSURANCE COVERAGE**

Is this patient a Ward of the State? <input type="checkbox"/> Yes <input type="checkbox"/> No	Case Manager:
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please complete appropriate insurance information below.</b>	
<b>MEDICARE COVERAGE (specify)</b>	<b>MEDICAID (WELFARE) COVERAGE</b>
Is Medicare Primary? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this patient covered by Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare #	Medicaid Plan #
Railroad Medicare #	Coventry NE #
Medicare (Hospital Only) #	Share Advantage #
Medicare Advantage Plan (Unicare, Secure Horizons, etc.)	Case Worker's Name:
Plan Name:	Case Worker's Phone:
Plan #	

**OTHER INSURANCE COVERAGE**

Insurance Company & Address:			Primary Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's Name	Subscriber's SSN	Subscriber's Date of Birth	Is this a Self/Individual Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
Policy #	Group #	Subscriber's Relationship to Patient	Subscriber's Employer

**OTHER INSURANCE COVERAGE**

Insurance Company & Address:			Primary Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's Name	Subscriber's SSN	Subscriber's Date of Birth	Is this a Self/Individual Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
Policy #	Group #	Subscriber's Relationship to Patient	Subscriber's Employer

(over)

1. What is your preferred pharmacy? \_\_\_\_\_ Location \_\_\_\_\_

2. Is this medical condition due to an accident of any kind? **YES NO**

If yes, was it (choose one): **Work Related Auto Home Other**

3. Do you have a Living Will or Advanced Directive (please bring a copy with you)? **YES NO**

4. Do you have a Medical Power of Attorney (please provide documentation)? **YES NO**

If yes, please indicate name, address & phone: \_\_\_\_\_  
\_\_\_\_\_

**MEDICARE PATIENTS ONLY** complete information in box:

If you are not a Medicare patient, please continue below the box.

1. Are you a Veteran? **YES NO**

If yes, were you referred to us by the VA? **YES NO**

If yes, do you have a written referral for today? **YES NO**

2. Do you have a Federal Black Lung Card? **YES NO**

3. Do you have a Veterans FEE BASIS ID card? **YES NO**

4. Are you covered by a current employer's health insurance plan through you or your spouse's employer?  
**YES NO**

5. Are you entitled to Medicare because of disability or End Stage Renal Disease? **YES NO**

→ **AUTHORIZATION TO TREAT**

I authorize and direct my physician and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate including but not limited to services involving pathology and radiology. I understand that I have the right to receive information, to ask questions and to receive answers to my questions about my treatment plan. I also have the right to refuse treatment and to seek a second opinion.

→ **ASSIGNMENT OF BENEFITS**

I hereby assign all medical and/or surgical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to the physician caring for me. **I understand that I am financially responsible for all allowed charges or co-insurance amounts which are not paid by my insurance company.**

→ **RELEASE OF INFORMATION TO INSURANCE COMPANY**

I authorize Urology, PC and/or Urology Surgical Center to release to the Medicare carrier and/or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to Urology, PC or Urology Surgical Center.

→ **NEBRASKA STATE LAW REGARDING MINORS** - Nebraska state law defines a minor as anyone 18 years of age and younger. These patients are required by this law to have a legal guardian present or if this is not possible, you must make prior arrangements with our office. If prior arrangements are not made, it could result in the appointment needing to be rescheduled.

→ I understand there will be a \$25 fee for a no show appointment or returned check (See also Financial Policy) payable only by cash, money order, credit or debit card.

**I understand that I will be responsible for all charges if the listed insurance information is not correct.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Date	Patient Name	Date of Birth	Sex	Ht	Wt
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Reason for Today's Visit:

**ALLERGIES (MEDICAL)**

To What	Reactions	To What	Reactions

Do you have a Latex Allergy or Sensitivity (circle one)?      **Allergy**      **Sensitivity**      **None**

Have you taken Cortisone, Prednisone, or Steroids for any condition in the past 6 months?    **No**    **Yes**

Any total joint or implant surgery?      **No**    **Yes**

Have you ever been told you have a heart condition which requires you to take antibiotics prior to medical or dental treatment?    **No**    **Yes** (list condition) \_\_\_\_\_

**MEDICATIONS / PRESCRIPTIONS / OVER-THE-COUNTER MEDICINE / INHALERS / VITAMINS / ASPIRIN**

Name & Dose	Frequency	Last Dose	Name & Dose	Frequency	Last Dose

**PREVIOUS SURGERIES / HOSPITALIZATION (LIST MOST RECENT FIRST)**

Type	Date

*Please check yes or no for each statement and if choices listed, circle each that apply to your health history:*

<b>FAMILY HISTORY (BLOOD RELATIVES)</b>	Yes	No	<b>SOCIAL HISTORY (Patient)</b>	Yes	No
Heart?			Smoker? If yes, packs per day?		
Hypertension (High Blood Pressure)?			Ex-Smoker? Quit Date:		
Bleeding tendencies?			Other tobacco use? How much?		
Cancer?			Alcohol use? How much?		
Diabetes?			Drug use? How much?		
Anesthetic problems? Fever during surgery?			Occupation:		
Neurological?			Religious restrictions?		
Any other medical conditions not addressed above?			COMMENTS:		

<b>CARDIOVASCULAR / HEART (Patient)</b>	Yes	No	<b>RESPIRATORY / LUNGS (Patient)</b>	Yes	No
High Blood Pressure?			History of asthma / wheezing?		
Chest pain at rest or during exercise?			Emphysema / COPD / Chronic bronchitis?		
Heart failure / Congestive heart failure?			Recent cold / flu / pneumonia?		
History of heart attack? Date:			Shortness of breath at rest or during exercise?		
Pacemaker?			Night sweats / tuberculosis / coughing up blood?		
Fainting / Dizzy?			Recent or chronic cough?		
History of Murmur / rheumatic fever / valve disorder?			COMMENTS:		
Has a doctor told you that you have a heart rhythm problem?					
Swelling in legs / Severe calf pain when walking?					

<b>HEMATOLOGY / BLOOD</b>	Yes	No	<b>KIDNEY / BLADDER</b>	Yes	No
Anemia?			Kidney disorder (failure / stones / infections)?		
Bleeding problems / bruise easily?			Dialysis patient?		
Leukemia / sickle cell anemia?			Kidney transplant?		
Blood Clots?			Burning with urination?		
Self-donated blood available?			Difficulty passing urine?		
Blood donated to you?			Difficulty controlling urine?		
Prior Transfusion?			Getting up at night to urinate? How many times?		
Transfusion reaction?			Blood in urine?		

COMMENTS:

COMMENTS:

# Urology, P.C. / Urology Surgical Center

# HEALTH HISTORY QUESTIONNAIRE

<b>ORTHOPEDIC / NEUROLOGICAL / MUSCULAR</b>	<b>Yes</b>	<b>No</b>	<b>GASTROINTESTINAL / STOMACH</b>	<b>Yes</b>	<b>No</b>
Arthritis?			Hiatal hernia / heartburn at night / reflux?		
Limited movement / Affected Area?			Ulcers / gastritis / vomiting blood?		
Seizure / epilepsy / convulsions?			Rectal problems or bleeding?		
Stroke / brief weakness / paralysis?			Recent change in bowel habits?		
Multiple sclerosis?			Frequent abdominal pain?		
Head injury?			Gallbladder problems?		
Muscle disorders / weakness / Cerebral Palsy?			Black tar-like bowel movements?		
Back or neck disorder?			COMMENTS:		
Amputation / prosthesis?					
Headaches?					
Parkinson's?					
			<b>LIVER</b>	<b>Yes</b>	<b>No</b>
Muscular dystrophy?			Hepatitis / cirrhosis?		
Painful or swollen joints?			Jaundice?		

<b>FEMALE GENITALIA</b>	<b>Yes</b>	<b>No</b>	<b>MALE GENITALIA</b>	<b>Yes</b>	<b>No</b>
Venereal disease (syphilis, gonorrhea, etc.)?			Prostate problem?		
Sexual problems?			Venereal disease (syphilis, gonorrhea, etc.)?		
Irregular periods?			Sexual Problems?		
Abnormal vaginal bleeding or spotting (not with periods)?			Discharge from penis?		
Severe cramps with periods?			Lump in testicles?		
Abnormal pap test?      Date of last pap test?			COMMENTS:		
Age at onset of periods:					
Periods are: <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light					
Date last menstrual period started:					
Could you be pregnant?					
Birth control method:			<b>INFECTIONS</b>	<b>Yes</b>	<b>No</b>
Number of full-term pregnancies:			Have you had any recent infections?		
Number of premature deliveries:			Have you been exposed to any infectious disease?		
Number of abortions or miscarriages:			Tetanus?                      Last Dose:		
Number of living children:			Hepatitis B?                      Last Dose:		
Cesarean birth?			Pneumo Vaccination?      Last Dose:		

<b>ENDOCRINE</b>	<b>Yes</b>	<b>No</b>	<b>GENERAL</b>	<b>Yes</b>	<b>No</b>
Diabetes? If yes, insulin dependent?			Cancer / Chemotherapy / Radiation Therapy?		
Problems with your glands? If yes, Thyroid, Pituitary, other			Anxiety / Depression / Psychiatric disorder?		
COMMENTS:			Cataracts / Glaucoma?		
			Recent Fall?		

<b>ANESTHESIA HISTORY</b>	<b>Yes</b>	<b>No</b>	<b>PEDIATRIC SURGERY INFORMATION</b>	<b>Yes</b>	<b>No</b>
Unexplained fever during surgery?			<b>If a child is having surgery:</b>		
Severe nausea and/or vomiting			Has your child had chicken pox?		
History of difficult intubations?			If not, has he/she been exposed in the past 3 weeks?		
Airway, breathing, sleep apnea, snoring problems?			<b>Was your child born prematurely?</b>		
Difficulty in waking after anesthesia?			If yes, how many weeks early?		
Dentures / bridgework / loose teeth?			Developmental delays as a child?		
History of TMJ / difficulty opening mouth?					

Additional Comments / Concerns:

Form Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Medications and Allergies reviewed by: \_\_\_\_\_



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L.A. Wiebusch, M.D.  
D.B. Wiltfong, M.D.

In order to accommodate the needs and requests of our patients we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of service *exactly* what those guidelines are.

Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently order services, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

Additionally, we will collect a co-pay as indicated on your insurance card. However, insurance policies vary and the possibility remains your insurance company may apply your charges to a deductible or require additional co-insurance to be paid by the patient. We have no control over how your claim is processed by your insurance company and any issues related to processing of claims must be addressed with your insurance carrier.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# UROLOGY, P.C./UROLOGY SURGICAL CENTER

5500 Pine Lake Road, Lincoln, NE 68516 Phone: (402) 489-8888 Fax: (402) 421-1945

## FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office and to assure you that Urology, P.C. / Urology Surgical Center is committed to providing you with the best possible care. Please read the following information regarding our Financial Policy.

If you have insurance coverage, as a courtesy, we will file ALL insurance claims, as long as an assignment of benefits is given to us. We participate with most of the major insurance companies. Please contact your insurance company if you have any questions regarding participation. Please remember the following regarding insurance:

- You are ultimately responsible for follow up with your insurance company regarding payment of your claim
- Your insurance is a contract between you and your insurance company
- Not all services are a covered benefit in all insurance policies
- You are responsible for any balance due on your account
- We reserve the right to pre-collect on any medical condition which may not be covered by insurance.

Please contact our billing department promptly at **402-489-8888 option 4** if you have questions or are unable to pay your bill in full within 30 days of the first statement you receive.

If you have no insurance coverage, you will be required to pay \$50 at the time of your visit; you will be billed for any additional charges. Payment arrangements are made in advance with our Patient Account Manager or billing department. To assist you, we accept cash, check, MasterCard, Visa and Discover. There will be a \$25 charge on all returned checks.

Remember to bring the following items along with you to your appointment:

- Your current insurance card
- Co-pay required by your insurance company
- A referral from your primary care physician, if your insurance requires one

Should you desire, we can provide you an estimate of your financial obligations regarding any proposed treatment/surgery. Please contact us promptly for assistance in the management of your account. We do use outside agencies as a means of collections should we deem it necessary. If you have any questions about the above information or any uncertainty regarding insurance coverage, do not hesitate to contact us at **402-489-8888 option 4**.

THERE WILL BE A \$25 FEE FOR ANY NO SHOWS WHICH MUST BE PAID PRIOR TO RESCHEDULING PAYABLE ONLY BY CASH, CREDIT OR DEBIT CARD, OR MONEY ORDER.