



**Pediatric New Patient Questionnaire**

Patient Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Gender: \_\_\_\_\_

Dear Patient,

A few minutes of your time carefully answering the following questions will help the Urologist in assessing your problems and giving you better care.

1. What is the main reason you are seeing the doctor today? \_\_\_\_\_  
 \_\_\_\_\_

2. Have you ever seen a Urologist before?  Yes  No

3. Were there any pre-natal (ultrasound) abnormalities noted? (i.e. Hydronephrosis)  Yes  No

4. Were there any abnormalities noted at birth or soon after? \_\_\_\_\_  
 \_\_\_\_\_

5. Are there any problems with:
- |  |   |
|--|---|
| <input type="checkbox"/> Night or Day Incontinence | <input type="checkbox"/> Undescended Testis             |
| <input type="checkbox"/> Urinary infection         | <input type="checkbox"/> Blood in urine                 |
| <input type="checkbox"/> Hernia or Hydrocele       | <input type="checkbox"/> Day or night urinary frequency |
| <input type="checkbox"/> Scrotal swelling          | <input type="checkbox"/> Urine stream problems          |
| <input type="checkbox"/> Abdominal or flank pain   |   |

6. PAST MEDICAL HISTORY Birthweight: \_\_\_\_\_

Operations:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medical:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Hospitalizations:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Current Medications:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Sibling medical problems:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medical problems that run in the family:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Pediatric New Patient Questionnaire (page 2)**

Patient Name:  
DOB:  
Age:  
Gender:

Do you now or have you had any problems with the following?

	YES	NO		YES	NO
<b>General</b>			<b>Musculoskeletal</b>		
Developmental problems	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral problems	<input type="checkbox"/>	<input type="checkbox"/>	Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>
School problems	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
<b>Head</b>			<b>Neurological</b>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Recent head injury	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
			Seizures	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ears/Nose/Mouth/Throat</b>			<b>Skin</b>		
Recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Chronic rash	<input type="checkbox"/>	<input type="checkbox"/>
Recent tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Non healing lesions	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergic/Immunologic</b>			<b>Psychiatric</b>		
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
			Mood changes	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory</b>			<b>Endocrine</b>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>
Recent URI	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiac</b>			<b>Hematologic/Lymphatic</b>		
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising/bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Heart Operations	<input type="checkbox"/>	<input type="checkbox"/>	Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal</b>					
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>			
Frequent nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>			
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
Frequent constipation	<input type="checkbox"/>	<input type="checkbox"/>			



**\*/SharedID-45\***

Patient Name: Lname, Fname  
DOB: /DOB  
Age: /Age  
Gender:/Sex

**Registration Form – Page 2**

Date: /TodayLong

**Secondary Insurance Coverage:** \_\_\_\_\_

Insurance Phone: \_\_\_\_\_

Claims Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name on ID Card: \_\_\_\_\_

Subscriber (person who holds the policy): \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Subscriber Social Security Number: \_\_\_\_\_

Patient's Relationship to Subscriber:  Patient  Spouse  Dependent  Other: \_\_\_\_\_

Subscriber's Address (if different from patient): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Policy ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Subscriber's Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Effective Date of Policy: \_\_\_\_\_

**AUTHORIZATION**

Our primary responsibility is to help our patients experience good health. Payment for services is expected to be paid at the time of service, including co-payments. If you do not pay your co-pay on the date of service, your appointment may need to be rescheduled.

Our billing office will submit all claims to your insurance carrier. Any outstanding balances are due at the time of the first billing.

I authorize the release of medical records or other information necessary to process my claims, as well as payment of medical benefits to Anne Arundel Urology, P.A./Anne Arundel Urological Surgery Center, LLC. I also acknowledge that I am responsible for any missed appointment or cancellation fees incurred.

I, \_\_\_\_\_, fully understand that I am responsible for payment of services rendered.

\_\_\_\_\_  
Patient Signature (Seal) Date

**Anne Arundel Urology, P.A.**

**Anne Arundel Urological Surgery Center, LLC**

600 Ridgely Avenue, Suite 130 & 223  
Annapolis, MD 21401

1600 Crain Highway, S.W., Suite 503  
Glen Burnie, MD 21061

**PRIVACY NOTICE TO PATIENTS**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- A. The General Authorization for Release of Medical Records that you may sign authorizes your medical care provider, Anne Arundel Urology, PA and/or Anne Arundel Urological Surgery Center, LLC (“Provider”), to disclose the information in your medical records to the extent needed for the following purposes:
1. For the purpose of providing treatment to you. This would include, for example, sharing information with the employees and contractors of Provider, or with other healthcare providers who are treating you or consulting your care.
  2. For the purpose of arranging payment for your care. This would include, for example, your insurer or third party payer who is responsible for paying all or part of the cost of your care.
  3. For the purpose of Provider’s “healthcare operations”. This would include such things as internal quality assessment activities, contacting other healthcare providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions or internal grievances and the provision of legal and auditing services.
  4. For the purpose of other healthcare providers’ “healthcare operations”, to the extent that they have a treatment relationship with you.
- B. A specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A above. A specific authorization will name the party to whom you are authorizing disclosure and will contain any limitations on the authority to disclose your records.
- C. You may revoke any authorization provided to Provider by giving written notice of revocation. Provider may refuse to treat you if you revoke the general authorization.
- D. Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.
- E. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

- F. You have the following rights with respect to your medical records/information:
1. You have the right to request authorization on the use and disclosure of your medical records/information; however, Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
  2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
  3. You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records.)
  4. You have the right to seek to amend your medical records and if Provider does not agree with your request, to note your objection in the medical record.
  5. You have the right to receive an accounting (list) of disclosures of your medical record/information made by Provider. (Except for those disclosures that are made to you or with your specific authorization, which fall within the scope of Provider's "healthcare operations" or disclosures made for payment or treatment purposes.)
  6. You have the right to receive a paper copy of this notice.
- F. Provider is required by law to maintain the privacy of protected health information and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices as appropriate.
- G. If a patient believes that his or her privacy rights have been violated, the patient may complain to Provider or to the Secretary of the U.S. Department of Health and Human Services. To complain to a Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.
- H. If you, as a patient or guardian, believe that your privacy rights have been violated and want to notify our office, please call and ask to speak with our designated contact person, Heather Achenbach.
- I. Provider reserves the right to change its privacy practices and to make its new policies effective for all protected health information that provider maintains. If such changes are made, Provider will issue an updated "Notice to Patients" to all of Provider's patients.

Patient Name:  
DOB:

## PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and have been provided the opportunity to review it.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_  
(Patient, Guardian or Lawfully Authorized Representative)

Date \_\_\_\_\_



## **DIRECTIONS TO ANNE ARUNDEL UROLOGY**

### ***ANNAPOLIS OFFICE***

#### **From Crofton, West Anne Arundel County, I-97**

- Route 50 East to the Bestgate Road/Rowe Blvd. Exit 24.
- Bear left onto Bestgate Road. Make the first right at the light onto North Bestgate Road. You will also see a small sign on the right pointing to Ridgely Avenue. After turning, you will pass St. John Neumann Church on the left.
- When you reach the stop sign, turn right onto Ridgely Avenue.
- We are less than a quarter mile down, left hand side of the road, in the Weems Creek Medical Center, which sits in a slightly recessed area just before Ridgely Avenue crosses over Route 50.
- Enter the doors facing Ridgely Avenue.
- We are on the first floor to the right as you enter the doors, Suite 130.

#### **From Severna Park via Route 2 and from the Eastern Shore**

- Route 50 West to the Bestgate Road/Rowe Blvd. Exit 24.
- Bear right onto Bestgate Road. Make the first right at the light onto North Bestgate Road. You will also see a small sign on the right pointing to Ridgely Avenue. After turning, you will pass St. John Neumann Church on the left.
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- Enter the doors facing Ridgely Avenue.
- We are on the first floor to the right as you enter the doors, Suite 130

*If you have any problems finding us, please call 410-266-8049 extension 100.*