Urology Group of Western New England, P.C.

3640 Main Street, 1st fl, Springfield, MA 01107
Phone (413) 785.5321 Fax (413) 731.7130

10 Main Street, Florence Ma 01062
Phone (413) 584.4278 Fax (413) 584.2985

Dear Patient:

Thank you for choosing the Urology Group of Western New England. In order to facilitate your care, please bring the following with you:

- The enclosed **Forms**, completed in their entirety
- Any information from your **PCP**, including labs, x-rays and office notes
- An Insurance **Referral**, if required
- A copy of your **Insurance Card**, as well as a **Photo ID**
- A means to pay your **Co-Pay**, if applicable
- A list of your current **Medications**

If you do not have insurance, payment is expected at the time of your appointment unless prior arrangements have been made.

Urology Group of Western New England utilizes *Physician Assistants* for some of our follow-up patient visits. Visits may be scheduled with a Physician Assistant so that we may see you more quickly. However, our Physician Assistants are always working in coordination with your doctor and his/her prescribed treatment plan.

If you need to cancel or re-schedule your appointment, please call at least 48 hours in advance. No-Shows and Late Cancellations may be subject to a fee.

Please do not hesitate to call the number at the bottom of this form if you have any questions.

Thank you.

Date and time of your appointment: _____
(Please arrive 15 minutes prior to your scheduled time in order to complete the registration process.)

Doctor you will be seeing:

___Susan D. Glover, MD ___Mohammad R. Mostafavi, MD ___Donald J. Sonn, MD

___Phillip S. Kick, MD ___William C. Tran, MD ___Adam Tyson, MD

Office: ____3640 Main St, 1st floor Springfield, MA 01107 413-785-5321

____ 10 Main Street, 2nd Floor, Florence, MA 01062 413-584-4278

____ 115 West Silver St, Westfield, MA 01075 413-785-5321

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Phone (413) 572-6041 Fax (413) 785-5321

The Urology Group of Western New England has been in practice in the Pioneer Valley area for approximately thirty years, caring for both adult and pediatric patients with urological diseases including blood in the urine, urinary incontinence, urinary infections, kidney, bladder and prostate disease, urologic malignancy, reflux, undescended testes, infertility, and sexual dysfunction. We are affiliated with Mercy Medical Center, and Cooley Dickinson Hospital. We are adept at "no scalpel" vasectomy, laparoscopic surgery (including the daVinci robot), prostate cryo-therapy, laser surgery, prostate surgery and microwave therapy, nerve-sparing prostatectomy, prostate ultrasound and biopsy, collagen procedures for incontinence, continent diversions for bladder cancer, shock-wave stone destruction, and difficult kidney-ureteral stone extraction using minimally invasive procedures.

All of our physicians are board certified and well trained general urological surgeons, and each has a subspecialty interest in areas of adult and pediatric urology.

Dr. Susan Glover practices all phases of urology and specializes in pediatric urologic surgery, female urology, and the treatment of female urinary incontinence. Dr. Glover is a graduate of Michigan State University and did her training at Akron City Hospital. She has been with the practice since 1988.

Dr. Mohammad Mostafavi did his urology training at the University of California, San Diego and completed a stone fellowship at Beth Israel Hospital. Dr. Mostafavi has been with the practice since 1997 and specializes in stone surgery and minimally invasive endourology.

Dr. Donald Sonn trained at the Long Island Jewish Medical Center. Dr. Sonn has been with the practice since 1997 with a specialty in impotence, prostheses, stones and brachytherapy for prostate cancer.

Dr. Phillip Kick graduated from Ohio State University Medical School and completed his residency at Case Western Reserve University. He specializes in urologic oncology, laparoscopic urology as well as general urology.

Dr. William Tran received his medical degree from the University of Massachusetts Medical School. He specializes in general urology, including kidney stone, urinary dysfunction, urethral stricture and erectile dysfunction, and in urologic oncology, including prostate, bladder and kidney cancers.

Dr. Adam Tyson trained at Jefferson Medical College, and completed his residency at University of Connecticut. He specializes in treating prostate and kidney cancer with robotic surgery, as well as treating all areas of general urology.

Urology Group of Western New England P.C.

Patient Information Sheet

PATIENT NAME: _____ SEX _____

ADDRESS: _____ D.O.B. _____

_____ MARITAL STATUS _____

_____ S.S.# _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PATIENT CONTACT INFORMATION

HOME PHONE: _____ EMAIL: _____

WORK PHONE: _____

CELL PHONE: _____

How would you like to receive appointment reminders?

☐ **Phone call** ☐ **Text message** ☐ **Email**

PATIENT EMPLOYMENT INFORMATION

(Give Information For Person Responsible If Patient Is A Minor or Student)

EMPLOYER _____

ADDRESS _____

_____

IS YOUR CURRENT CONDITION RELATED TO

	YES	NO
Employment?	☐	☐
Auto Accident?	☐	☐
Other Accident?	☐	☐

BILLING RESPONSIBILITY (Only If Patient Is A Minor - Otherwise Patient Is Responsible Party)

SEND BILLS TO _____ PHONE _____

ADDRESS _____

EMERGENCY CONTACT

NAME _____ PHONE _____

INSURANCE INFORMATION

PRIMARY _____ INS ID# _____

INSURED _____ RELATION _____ D.O.B. _____

SECONDARY _____ INS ID# _____

INSURED _____ RELATION _____ D.O.B. _____

PHARMACY

NAME _____ PHONE _____

ADDRESS _____

PLEASE READ CAREFULLY AND THOROUGHLY. IF YOU HAVE ANY QUESTIONS, PLEASE ASK BEFORE SIGNING.

UROLOGY GROUP OF WESTERN NEW ENGLAND, PC

AUTHORIZATION

NAME OF PATIENT: _____

I, the undersigned, hereby authorize payment directly to Urology Group of Western New England P.C. of medical / surgical benefits, if any, otherwise payable to me under the terms of my health insurance policy.

I fully understand that I am primarily and financially responsible for fees incurred by the above patient; I further understand that payment to said medical practice is not contingent on any settlement, judgment or verdict by which the above patient may eventually recover said medical / surgical fees.

I hereby authorize medical / surgical treatment, care and/or services by Urology Group of Western New England P.C. to the above patient.

I hereby authorize Urology Group of Western New England P.C. to release information that may be needed to process my claim for payment to my third party insurance carrier.

I hereby authorize any physician, health care practitioner, hospital or medical care facility to provide all information on the above patient's medical history to Urology Group of Western New England P.C.

I hereby authorize Urology Group of Western New England to release the above patient's medical information to any physician that is involved in the above patient's medical care. Any other requested medical information, e.g. HIV, STD's and/or substance above, attorney requests, family members, spouses, etc., will require a secondary written authorization form.

I hereby authorize photocopies of this form to be valid as the original.

I certify that I have read and fully understand the above authorizations.

DATE _____ SIGNATURE: _____

RELATION: _____

Urology Group of Western New England, P.C.

3640 Main Street, Ste 103, Springfield, MA 01107 Tel 413-785-5321 Fax 413-731-7130
10 Main Street, 2nd Floor, Northampton, MA 01062 Tel 413-584-4278 Fax 413-584-2985
115 West Silver St, 1st Floor, Westfield, MA 01075 Tel 413-785-5321 Fax 413-731-7130

Acknowledgement of Receipt of *Notice of Health Information Practices*

I have been presented with a copy of Urology Group of Western New England's *Notice of Health Information Practices*, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

RESTRICTIONS: _____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

I authorize Urology Group of Western New England to leave me messages regarding appointments on my answering machine.

****

I further authorize Urology Group of Western New England to speak to the following individuals about my care:

Name: _____ Relation: _____

Name: _____ Relation: _____

****

Signed: _____ **Date**: _____

Printed Name:

Date of Birth:

If not signed by patient, please indicate relationship to patient:

Relationship: _____ **Witness**: _____

****

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time): _____

By: (name and title) : _____

Urology Group of Western New England PC
3640 Main Street, Suite 103
Springfield, MA 01107

As of: 02/16/2016

Patient: _____ D.O.B._____

Insurances we Do Not Participate With

Aetna Excel Plan
Ambetter
Anthem HMO Blue Care New England
Celtic Care
Connecticare Medicare Replacement Plan
Fallon Connector Plan
Fallon MassHealth
Fallon Summit Elder Care
Fallon Total Care
Harvard Pilgrim Focus Network
Harvard Pilgrim GIC Primary Choice Plan
Health New England Be Healthy
Health New England Care Plan
MassHealth - Except Dr. Mostafavi
MassHealth Health Safety Net
Neighborhood Health Plan
One Care Medicare Masshealth Replacement
Oxford (Unless have out-of-network benefits)
RiverBend Pace Program
Tufts Spirit Plan
United Health Care Evercare Medicaid Only Community

I understand that this list may not be inclusive of all plans that UGWNE does not participate with. I understand it is my responsibility to ensure that my provider participates with my insurance carrier.

_____

Patient Signature Date

New Patient Questionnaire

UROLOGY GROUP OF WESTERN NEW ENGLAND, PC

Last Name:	First Name:	
Date of Birth:	Today's Date:	
Primary Care Provider:	Last Name:	First Name:

If you take any medications, please write them below. Use the back for more space.

Medication	Strength and frequency	Reason for taking

Are you allergic to any medication or product?			□ Yes	□ No
If yes, please list and explain:				
Are you allergic to latex?			□ Yes	□ No
Do you currently smoke?			□ Yes	□ No
If no, did you smoke in the past?			□ Yes	□ No
How much and for how many years are you smoking (or smoked) in the past?				
cigarettes:	packs per day	years		
cigars:	per day	years		
pipe:		years		
Do you drink alcoholic beverages?		□ Yes	□ No	Amount:
Do you have a history of alcohol abuse?		□ Yes	□ No	Describe:
Do you have a history of substance abuse?		□ Yes	□ No	Describe:
Are you currently:	□ Single	□ Married	□ Divorced	
□ Engaged	□ Partnered	□ Separated	□ Widowed	
Do you have any children?		□ Yes	□ No	How many?
Is there family history of prostate cancer?		□ Yes	□ No	Explain:
Is there family history of kidney cancer?		□ Yes	□ No	Explain:
Is there family history of bladder cancer?		□ Yes	□ No	Explain:
Is there family history of stones?		□ Yes	□ No	Explain:
Is there family history of any other diseases?		□ Yes	□ No	Explain:

UROLOGY GROUP OF WESTERN NEW ENGLAND

Do you suffer from any of the following medical conditions?			Have you had any of the following surgeries?		
Alzheimer's dx.	□ Yes	□ No	Appendectomy	□ Yes	□ No
Arrhythmias	□ Yes	□ No	Breast surgery	□ Yes	□ No
Arthritis	□ Yes	□ No	□ Cancer	□ Non-cancer	
Asthma	□ Yes	□ No	Cataract surgery	□ Yes	□ No
Atrial fibrillation	□ Yes	□ No	Gall bladder removal	□ Yes	□ No
Blood clot	□ Yes	□ No	Colon resection	□ Yes	□ No
Cancer	□ Yes	□ No	□ Cancer	□ Non-cancer	
describe:			Deliveries	□ Yes	□ No
			# of pregnancies:		
			# of vaginal deliveries:		
COPD	□ Yes	□ No	# of C - sections:		
Crohn's disease	□ Yes	□ No	# of miscarriages:		
Diabetes, Type I	□ Yes	□ No	Heart Angioplasty	□ Yes	□ No
Diabetes, Type II	□ Yes	□ No	Heart bypass surgery	□ Yes	□ No
Diverticulosis	□ Yes	□ No	Heart Pacemaker	□ Yes	□ No
Endometriosis	□ Yes	□ No	Heart Stent placement	□ Yes	□ No
Fibromyalgia	□ Yes	□ No	Heart valve surgery	□ Yes	□ No
Acid reflux	□ Yes	□ No	Hemorrhoidectomy	□ Yes	□ No
Glaucoma	□ Yes	□ No	Hernia repair	□ Yes	□ No
Heart attack	□ Yes	□ No	Herniated disc surgery	□ Yes	□ No
Herniated disc	□ Yes	□ No	describe:		
describe:			Hysterectomy, uterus only	□ Yes	□ No
High Cholesterol	□ Yes	□ No	□ Cancer	□ Non-cancer	
High blood pressure	□ Yes	□ No	□ Vaginal	□ Abdominal	
Multiple sclerosis	□ Yes	□ No	Hysterectomy, uterus and ovaries		
Osteoporosis	□ Yes	□ No		□ Yes	□ No
Pancreatitis	□ Yes	□ No	□ Cancer	□ Non-cancer	
Paralysis	□ Yes	□ No	□ Vaginal	□ Abdominal	
Parkinson's disease	□ Yes	□ No	Lung surgery	□ Yes	□ No
Pneumonia	□ Yes	□ No	□ Cancer	□ Non-cancer	
Pulmonary emboli	□ Yes	□ No	Tonsillectomy	□ Yes	□ No
Renal failure	□ Yes	□ No	Total Joint replacement	□ Yes	□ No
Stroke	□ Yes	□ No	□ Knee	□ Hip	
Thyroid disorder	□ Yes	□ No	□ Shoulder	□ other	
□ hypo-active	□ hyper-active		Transplant surgery	□ Yes	□ No
Ulcerative colitis	□ Yes	□ No	describe:		
Please write below any other conditions:			Please write below any other surgeries:		

UROLOGY GROUP OF WESTERN NEW ENGLAND

Do you have any complaints with the following; please check all that apply:			
Are you losing weight (not intentionally)?		□ Yes	□ No
Eyes	blurred vision	□ Yes	□ No
	vision loss	□ Yes	□ No
Ears, Nose, Throat	decreased hearing	□ Yes	□ No
Cardiovascular	chest pain	□ Yes	□ No
	heart murmur	□ Yes	□ No
	swelling of legs	□ Yes	□ No
Pulmonary	cough	□ Yes	□ No
	wheezing	□ Yes	□ No
Gastrointestinal	constipation	□ Yes	□ No
	diarrhea	□ Yes	□ No
Genitourinary (general)	urinary frequency	□ Yes	□ No
	urinary urgency	□ Yes	□ No
	urinary leakage (incontinence)	□ Yes	□ No
	weak stream	□ Yes	□ No
Genitourinary (male patient)	male sexual problems	□ Yes	□ No
	decreased libido	□ Yes	□ No
Genitourinary (female patient)	last PAP smear	Date:	
	□ Normal	□ Abnormal	
	regular menses	□ Yes	□ No
	menopausal	□ Yes	□ No
	post menopausal	□ Yes	□ No
	last mammography	Date:	
	□ Normal	□ Abnormal	
	female sexual problems	□ Yes	□ No
	decreased libido	□ Yes	□ No
Musculoskeletal	muscle pain	□ Yes	□ No
Integumentary	hair loss	□ Yes	□ No
Neurological	headaches	□ Yes	□ No
Psychiatric	depression	□ Yes	□ No
Endocrine	hot flashes	□ Yes	□ No
Hematologic	easy bruising	□ Yes	□ No
Immunologic	persistent infections	□ Yes	□ No

Employment status - please check all that apply to you:	
□ Employed	Company:
□ Self-employed	Describe:
□ Retired	
□ Semi-retired	
□ Unemployed	
□ Student	
□ Disability	

Name and Date:

American Urological Association BPH Symptom Score Index Questionnaire

Point Scale	Not at all 0	Less than 1 time in 5 1	Less than half the time 2	About half the time 3	More than half the time 4	Almost Always 5

1. **Incomplete emptying** Over the last month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Frequency During the last month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
3. Intermittency During the last month, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Urgency During the last month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Weak stream During the last month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Straining During the last month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. Nocturia During the last month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Now add up your Symptom Score (1-7 Mild, 8-19 Moderate, 20-35 Severe):