Dear Patient,

Thank you for choosing Hackensack University Medical Group | Urology. We look forward to meeting you and providing you with the highest quality urological care. In addition to our physicians, nurses and clinical assistants, who will look after your medical needs; our administrative staff is here to help you with scheduling, billing, and other non-clinical issues. Please take a few minutes, prior to your first visit, to complete and review the following information related to our practice. Doing so, will enable us to serve you as efficiently as possible.

Office hours by appointment
To schedule an appointment please call (551) 996-8090

Included in this packet for your review and completion are the following:

- Registration Form
- New Patient Information Form
- Questionnaire(s)
- Directions & Map

In addition, we ask that you bring the following to your appointment:

- Completed Forms
- Drivers license or legal form of picture ID
- Insurance Card
- Insurance co-pay
- List of medications and allergies
- Any and all radiology films & reports – Please provide any radiology images (e.g. X-Ray, MRI, Cat Scan, and/or Ultrasound), or study results relating to your visit

While under the care of our physicians if you need to renew a prescription, please call your pharmacy or fill out the online prescription renewal form, found on our website, urologynj.com.

Please note HackensackUMG | Urology has a no-show policy. Kindly cancel or reschedule your appointment at least 24 hours in advance. If a patient is scheduled for an appointment and does not cancel or reschedule, a letter will be sent to the patient charging them $25.

For billing questions contact your billing representative within the department at 551-996-8626. For all billing inquiries and details on your statement please contact HackensackUMG’s Billing Office at (866) 571-9238.

Our goal is to provide you with exceptional service and state of the art patient-centered medical care in an environment that is sensitive to your needs. Please let us know how we are doing or how we may improve our service and do not hesitate to call us if you have any questions.

Thank you again for choosing HackensackUMG | Urology and we look forward to meeting you.
Patient Information

Date: ___________________________  SSN#: ___________________________

Last Name: _______________________  First Name: _______________________

Date of Birth: _____________________  Gender:  Male  Female

Address: __________________________________________________________

City: _____________________________  State: _______  Zip: ___________

Special Living Arrangements:  None  Assisted Living  Nursing Home

Home Phone: _______________________  Cell Phone: ___________________

E-mail Address: ____________________________

Race:  American Indian/Alaska Native  Asian  African American/Black
       Native Hawaiian/Pacific Islander  White/Caucasian

Ethnicity:  Central/South American  Cuban  Mexican  Puerto Rican
          Other Hispanic/Latino  Non-Hispanic/Latino

Preferred Language: _________________  Marital Status: _________________

Employment:  Employed  Medical Disability  Self-Employed  Retired  Unemployed

Employer: _________________________  Employer Address: _________________

Emergency Contact: _____________________  Relation: __________________

Address: _____________________________  Phone # ___________________

Pharmacy Name: _______________________  Phone # ___________________

How did you hear about us: __________________________________________

Primary Physician Information

NAME: ___________________________________________________________

ADDRESS: _______________________________________________________

PHONE #: _______________________________________________________

____________________________________________________________

Patient’s Signature                          Date
Insurance Information

Primary Insurance

Name of Policy Holder/Guarantor: ___________________________ DOB: ________

Relationship to Patient: ___________________________ SSN#: _____________________

Policy Holder/Guarantor’s Address: ________________________________

Status: Employed  Medical Disability  Self-Employed  Retired  Unemployed

Employer: ___________________________ Employer Address: __________________

Insurance Company: ___________________________ Phone #: ________________

Insured’s Policy/ ID #: ___________________________ Group #: _____________________

Insurance Co. Address: ___________________________ Phone #: ________________

Name of Lab Determined by Insurance: ________________________________

--------- DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No ---------

IF YES, PLEASE COMPLETE THE FOLLOWING:

Secondary Insurance

Name of Policy Holder/Guarantor: ___________________________ DOB: ________

Relationship to Patient: ___________________________ SSN#: _____________________

Policy Holder/Guarantor’s Address: ________________________________

Status: Employed  Medical Disability  Self-Employed  Retired  Unemployed

Employer: ___________________________ Employer Address: __________________

Insurance Company Address: ________________________________

Insured’s Policy/ ID #: ___________________________ Group #: _____________________

Insurance Co. Address: ___________________________ Phone #: ________________

PLEASE PROVIDE INSURANCE CARDS AND PICTURE ID TO FRONT DESK

MAKE CHECKS PAYABLE TO “HUMG”
Female Incontinence Questionnaire

1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating, had a weak stream, or had to push or strain to urinate?
   ______0 None
   ______1 Less than half the time
   ______2 About half the time
   ______3 Almost always

2. Over the past month, how often have you found it difficult to postpone urination?
   ______0 None
   ______1 Less than half the time
   ______2 About half the time
   ______3 Almost always

3. Over the past 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 None
   ______1 Once or twice per night
   ______2 Three to four times per night
   ______3 Five or more times per night

4. Over the past month, how many times during the day did you typically have to urinate?
   ______0 Every 3 to 4 hours or less
   ______1 Every 2 to 3 hours
   ______2 Every 1 to 2 hours
   ______3 Every half-hour or more
5. Over the past month, how often have you had urine leakage related to activity such as coughing, sneezing or exercise?

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>1</td>
<td>Less than once per week</td>
</tr>
<tr>
<td>2</td>
<td>At least once per week</td>
</tr>
<tr>
<td>3</td>
<td>At least once per day</td>
</tr>
</tbody>
</table>

6. Over the past month, how often have you leaked because of a strong urge to urinate?

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>1</td>
<td>Less than once per week</td>
</tr>
<tr>
<td>2</td>
<td>At least once per week</td>
</tr>
<tr>
<td>3</td>
<td>At least once per day</td>
</tr>
</tbody>
</table>

7. Over the past month, how often have you leaked without activity or urge?

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>1</td>
<td>Less than once per week</td>
</tr>
<tr>
<td>2</td>
<td>At least once per week</td>
</tr>
<tr>
<td>3</td>
<td>At least once per day</td>
</tr>
</tbody>
</table>

8. If you leak with activity, over the past month, at what level of activity did you experience leakage?

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No leakage</td>
</tr>
<tr>
<td>1</td>
<td>Leakage only with strenuous exercise or activity</td>
</tr>
<tr>
<td>2</td>
<td>Leakage with moderate activity such as walking, coughing or lifting</td>
</tr>
<tr>
<td>3</td>
<td>Leakage with minimal activity</td>
</tr>
</tbody>
</table>

9. Over the past month, how often have you used pads for protection?

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never</td>
</tr>
<tr>
<td>1</td>
<td>Only on certain occasions</td>
</tr>
<tr>
<td>2</td>
<td>Daily for occasional accidents</td>
</tr>
<tr>
<td>3</td>
<td>Daily for frequent accidents or constant leakage</td>
</tr>
</tbody>
</table>

10. How much are you bothered by your symptoms?

    | Level | Description |
    |-------|-------------|
    | 0     | Not at all   |
    | 1     | Slightly     |
    | 2     | Moderately   |
    | 3     | Greatly      |
# New Patient Information Form

## Patient Information
- **Name:** [Name]
- **Height:** [Height]
- **Weight:** [Weight]
- **BP:** [BP]
- **Pulse:** [Pulse]
- **Date of Birth:** [Date]
- **Address:** [Address]
- **Phone:** [Phone]
- **Work:** [Work]
- **Emergency:** [Emergency]

### History of Present Illness / Diagnosis
- **Location:** [Location]
- **Description:** [Description]
- **Examples:** Color of Sputum
- **Severity:** How severe is the pain / problem?
- **Duration:** How long have you had this - when did it start?
- **Timing:** Does the pain / problem occur at a specific time?
- **Context:** Where were you at the onset of this pain / problem?
- **Associated Signs / Symptoms:** What other problems have you been having?
- **Modifying Factors:** What makes the pain / problem worse or better?
- **Medical History:** Have you had any previous episodes?

### Previous Hospitalizations / Surgeries / Serious Injuries
- [List previous hospitalizations, surgeries, and serious injuries]

### Patient Social History
- **Marital Status:**
  - [List marital status: Single, Married, Divorced, Widowed]
- **Use of Alcohol:**
  - [Never, Rarely, Previously But Quit, Currently, Daily]
- **Use of Tobacco:**
  - [Never, Previously But Quit, Currently, Packs Daily]
- **Use of Drugs:**
  - [Never, Type & Frequency]
- **Excessive Exposure at Home or Work To:**
  - [Fumes, Solvents, Chemicals, Other]

### Family Medical History
- **Father:**
  - [Age, Diseases, If Deceased, Cause of Death]
- **Mother:**
  - [Age, Diseases, If Deceased, Cause of Death]
- **Brothers:**
  - [Age, Diseases, If Deceased, Cause of Death]
- **Sisters:**
  - [Age, Diseases, If Deceased, Cause of Death]
- **Spouse:**
  - [Age, Diseases, If Deceased, Cause of Death]
- **Children:**
  - [Age, Diseases, If Deceased, Cause of Death]
### System Review

#### 1) Respiratory
- Chronic or Frequent Cough: □ Yes □ No
- Spitting Up Blood: □ Yes □ No
- Shortness Of Breath: □ Yes □ No
- Asthma or Wheezing: □ Yes □ No

#### 2) Psychiatric
- Memory Loss or Confusion: □ Yes □ No
- Nervousness: □ Yes □ No
- Depression: □ Yes □ No
- Insomnia: □ Yes □ No

#### 3) Eyes
- Eye Disease or Injury: □ Yes □ No
- Wear Glasses / Contact Lenses: □ Yes □ No
- Blurred or Double Vision: □ Yes □ No
- Glaucoma: □ Yes □ No

#### 4) Hematologic / Lymphatic
- Slow to Heal After Cuts: □ Yes □ No
- Bleeding or Bruising Tendency: □ Yes □ No
- Anemia: □ Yes □ No
- Phlebitis: □ Yes □ No
- Past Transfusion: □ Yes □ No
- Enlarged Lymph Nodes: □ Yes □ No

#### 5) Constitutional Symptoms
- Good General Health Lately: □ Yes □ No
- Recent Weight Change: □ Yes □ No
- Fever: □ Yes □ No
- Fatigue: □ Yes □ No
- Headaches: □ Yes □ No

#### 6) Cardiovascular
- Heart Trouble: □ Yes □ No
- Chest Pain: □ Yes □ No
- Angina: □ Yes □ No
- Palpitations: □ Yes □ No
- Shortness of Breath while Walking or Lying: □ Yes □ No
- Swelling of Feet or Ankles: □ Yes □ No

#### 7) Musculoskeletal
- Joint Pain: □ Yes □ No
- Joint Stiffness or Swelling: □ Yes □ No
- Weakness of Muscles or Joints: □ Yes □ No
- Muscle Pain or Cramps: □ Yes □ No
- Back Pain: □ Yes □ No
- Cold Extremities: □ Yes □ No
- Difficulty in Walking: □ Yes □ No

#### 8) Integumentary
- Rash or Itching: □ Yes □ No
- Change in Skin Color: □ Yes □ No
- Change in Hair or Nails: □ Yes □ No
- Varicose Veins: □ Yes □ No
- Breast Pain: □ Yes □ No
- Breast Lump: □ Yes □ No
- Breast Discharge: □ Yes □ No

#### 9) Endocrine
- Glandular or Hormone Problems: □ Yes □ No
- Thyroid Disease: □ Yes □ No
- Diabetes: □ Yes □ No
- Excessive Thirst or Urination: □ Yes □ No
- Heat or Cold Intolerance: □ Yes □ No
- Skin Becoming Dryer: □ Yes □ No
- Change in Hat or Glove Size: □ Yes □ No

#### 10) Ears, Nose, Mouth & Throat
- Hearing Loss or Ringing: □ Yes □ No
- Earaches or Drainage: □ Yes □ No
- Chronic Virus Problems or Rhinitis: □ Yes □ No
- Nose Bleeds: □ Yes □ No
- Mouth Sores: □ Yes □ No
- Bleeding Gums: □ Yes □ No
- Bad Breath or Bad Taste: □ Yes □ No
- Sore Throat or Voice Change: □ Yes □ No
- Swollen Glands in Neck: □ Yes □ No

#### 11) Gastrointestinal
- Loss of Appetite: □ Yes □ No
- Nausea or Vomiting: □ Yes □ No
- Frequent Diarrhea: □ Yes □ No
- Painful Bowel Movements or Constipation: □ Yes □ No
- Rectal Bleeding or Blood in Stool: □ Yes □ No
- Abdominal Pain or Heartburn: □ Yes □ No
- Peptic Ulcer (Stomach or Duodenal): □ Yes □ No

#### 12) Neurological
- Frequent or Recurring Headaches: □ Yes □ No
- Light Headed or Dizzy: □ Yes □ No
- Convulsions or Seizures: □ Yes □ No
- Numbness or Tingling Sensation: □ Yes □ No
- Tremors: □ Yes □ No
- Paralysis: □ Yes □ No
- Stroke: □ Yes □ No
- Head Injury: □ Yes □ No

#### 13) Genitourinary
- Frequent Urination: □ Yes □ No
- Burning or Painful Urination: □ Yes □ No
- Blood in Urine: □ Yes □ No
- Change in Force of Stream when Urinating: □ Yes □ No
- Incontinence or Dribbling: □ Yes □ No
- Kidney Stones: □ Yes □ No
- Sexual Difficulty: □ Yes □ No
- Male - Testicle Pain: □ Yes □ No
- Female - Pain with Periods: □ Yes □ No
- Female - Irregular Periods: □ Yes □ No
- Female - Vaginal Discharge: □ Yes □ No
- Female - Number of Pregnancies: □ Yes □ No
- Female - Number of Miscarriages: □ Yes □ No
- Female - Date of Last Pap Smear: □ Yes □ No
- Female - First Menstrual Period: □ Yes □ No
- Female - Last Menstrual Period: □ Yes □ No
- Oral Contraceptive Pills: □ Yes □ No
- Hormone Replacement Therapy: □ Yes □ No

#### 14) Allergic / ImmunoLOGIC
- History of Skin Reaction or Adverse Reaction To:
  - Penicillin or Other Antibiotics: □ Yes □ No
  - Morphine, Demerol or Other Narcotics: □ Yes □ No
  - Novocaine or Other Anesthetics: □ Yes □ No
  - Aspirin or Other Pain Remedies: □ Yes □ No
  - Tetanus Antitoxins or Other Serums: □ Yes □ No
  - Iodine, Methylolate or Other Antiseptics: □ Yes □ No
  - Other Drugs / Medicines: □ Yes □ No
  - Known Food Allergies: □ Yes □ No

If You Answered Yes To Any Questions, Explain Below or on Back of this Sheet:

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
**PLEASE INFORM THE DOCTOR OF ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Including ASPIRIN)**

<table>
<thead>
<tr>
<th>MEDICATION NAME</th>
<th>STRENGTH (i.e. mgs etc)</th>
<th>DOSAGE (i.e. amount &amp; when taken)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2)</td>
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<tr>
<td>12)</td>
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</tbody>
</table>
Directions from Paterson Area and West
Follow Route 80 East, staying in local lanes to Exit 63B for Rochelle Park and Paramus. (Exit ramp sign says Exit 63). Turn left off exit ramp and turn right at light onto Essex Street. Follow Hospital signs. At fifth light, turn left onto Summit Avenue. Turn immediate right onto Thompson Street to access our underground parking garage. Take the elevators to the 4th floor.

From George Washington Bridge East
Follow Route 80 West, staying in local lanes, to Exit 64B. Turn right at light onto Polifly Road. Travel north on Polifly Road. At second light, turn left onto Essex Street. At first light, turn right onto Prospect Avenue. Make an immediate left onto Thompson Street to access our underground parking garage. Take the elevators to the 4th floor.

From Southern New Jersey via the New Jersey Turnpike
Follow Route 95-N.J. Turnpike North to the junction of Route 80. Take 80 West and stay in lanes for "Local Exits" to exit 64B for Hasbrouck Heights and Newark. Turn right at light onto Polifly Road. Travel north on Polifly Road. At second light, turn left onto Essex Street. At first light, turn right onto Prospect Avenue. Make an immediate left onto Thompson Street to access our underground parking garage. Take the elevators to the 4th floor.

From Northern New Jersey on Route 17
Follow Route 17 South to Essex Street exit. Turn left onto Essex Street. At fourth light, turn left onto Summit Avenue. Turn immediate right onto Thompson Street to access our underground parking garage. Take the elevators to the 4th floor.

From Southern New Jersey on Route 17
Follow Route 17 North to Polifly Road turnoff. Go under the Route 80 overpass and turn left at the second light onto Essex Street. At first light, turn right onto Prospect Avenue. Make an immediate left onto Thompson Street to access our underground parking garage. Take the elevators to the 4th floor.

From the Lincoln Tunnel
Take Route 3 West to Route 17 North to Essex Street exit. Turn right onto Essex Street. At second light, turn left onto Summit Avenue. Turn immediate right onto Thompson Street to access our underground parking garage. Take the elevators to the 4th floor.

From the Garden State Parkway
From the Garden State Parkway, either north or south, take Route 80 East. Follow directions above for Paterson Area and West.