



A Division of Garden State Urology

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*Pediatric Urology*

*Diplomats of the American Board of Urology*

Adult Urology  
Pediatric Urology  
Urologic Oncology  
Male Infertility  
Sexual Dysfunction  
Urodynamics  
Stone Disease  
Female Urology  
Cryosurgery  
HIFU  
Laparoscopic Surgery  
Reconstructive Urology  
Robotic Surgery

Main office:

261 James Street, Suite 1A  
Morristown, NJ 07960  
973.539.1050  
Fax 973.538.6111  
[www.muaji.com](http://www.muaji.com)

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Morristown, NJ 07960  
973.656.0600  
Fax 973.656.0200



Dear New Patient,

**Welcome to our practice!**

Our staff is dedicated to making your visit as comfortable as possible and achieving the highest level of care. Please assist us in our goals by carefully reading the following instructions and completing all forms in their entirety.

Please remember to arrive 15 minutes prior to your scheduled appointment with the following or it may result in you having to wait until the proper documents are obtained by us.

1. Completed **Pediatric** New Patient Packet
  - Pediatric Registration Form
  - Review of Past Medical History
  - Personal History
  - Signed Acknowledgement of Receipt of Notice of Privacy Practices
  - Signed Acknowledgement Form For The Financial Information Document
2. Guardian's photo ID (license, passport, VISA)
3. Insurance cards
4. Referral, if it is required by insurance
5. Lab results, especially all urine cultures
6. Radiology testing, especially VCUG or ultrasounds (reports **and** films/CD) \* It is your responsibility to hand deliver these items to your appointment. You should not rely on the facility to deliver them.
7. A list of current medications the child is taking
8. Any other tests or medical results that pertain to your visit
9. Voiding Diary if required (**it must include several consecutive days including 1 weekend**)
10. Wetting questionnaire if required

If you have any questions prior to your visit, do not hesitate to call. We look forward to seeing you for your appointment.

Sincerely,

The Scheduling Staff  
Morristown Urology

**PEDIATRIC REGISTRATION FORM**

Patient's Name: \_\_\_\_\_ Home Phone#: \_\_\_\_\_

First Middle Last

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_ Patient's Sex: Male Female  
Patient's Social Security#: \_\_\_\_\_ Race: \_\_\_Caucasian \_\_\_African American \_\_\_Hispanic  
\_\_\_American Indian \_\_\_Asian Indian/Pakistani \_\_\_Asian \_\_\_Mixed \_\_\_Other: \_\_\_\_\_

**Parent Information:**

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Home Address: \_\_\_\_\_  
Mother's Birth Date: \_\_\_\_\_ Father's birth date: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Work Number: \_\_\_\_\_ Work Number: \_\_\_\_\_  
Cell Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

If parents are divorced or separated is there a court order or other financial arrangement we need to be aware of?  
\_\_\_\_\_ Name of Step Parent \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Home/Cell#: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Pediatrician Name:** \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone # \_\_\_\_\_

**Referring Doctor** (if different from Pediatrician) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone #: \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_ Town: \_\_\_\_\_ Phone #: \_\_\_\_\_

**INSURANCE INFORMATION (Must be completed in full so that we may submit to your insurance for reimbursement.)**

**Primary Insurance:** \_\_\_\_\_

Policyholder's Information:

Name (insured's name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: Male Female Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Patient's relationship to insured (please circle): Child Other/ Dependent

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

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

Policyholder's Information:

Name (insured's name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: Male Female Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Patient's relationship to insured (please circle): Child Other/ Dependent

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

I request that payment of authorized Medicare, Medicaid, and/or commercial insurance benefits be made to Garden State Urology, LLC, for any service furnished to me by GSU's physicians. I authorize Garden State Urology, LLC to release medical information which may be required by my insurance carrier to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due the physician. These amounts could include annual deductibles, co-payments, charges denied as not covered by Medicare or my insurance program, and charges denied for services determined as not medically necessary.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Chart #: \_\_\_\_\_

**Morristown Urology Associates, P.A.**  
**Review of Past Medical History**  
**Pediatric format**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT HEIGHT: \_\_\_\_\_ PATIENT WEIGHT: \_\_\_\_\_

Please tell us the reason for your child's visit today: \_\_\_\_\_

\_\_\_\_\_

Were there any problems with your child diagnosed before he/she was born? \_\_\_\_\_

\_\_\_\_\_

Please list any past or present medical conditions: \_\_\_\_\_

\_\_\_\_\_

Please list any surgeries your child has had: \_\_\_\_\_

\_\_\_\_\_

Please list all current medications: Medication Dosage:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any allergies your child has to

Medications:

Food:

Latex:

Is there a family history of:

urinary tract infection                      Yes      No

bedwetting                                      Yes      No

undescended testis                          Yes      No

hypospadias (penile abnormality)        Yes      No

kidney disease                                Yes      No

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Chart #: \_\_\_\_\_

## Personal History

DO YOU HAVE ANY PROBLEMS RELATED TO THE FOLLOWING SYSTEMS?

(circle YES or NO)

### Constitutional:

Fever	Y	N
Chills	Y	N
Other	_____	

### Hematological/Lymphatic:

Clotting Problem	Y	N
Swollen Glands	Y	N
Blood Transfusions	Y	N
Other	_____	

### Psychological:

Depression	Y	N
Psychosis	Y	N
Other	_____	

### Neurological:

Seizures	Y	N
Other	_____	

### Endocrine:

Excessive Thirst	Y	N
Diabetes Mellitus	Y	N
Other	_____	

### Gastrointestinal:

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Other	_____	

### Cardiovascular:

High Blood Pre	Y	N
Heart Murmur	Y	N
Other	_____	

### Integumentary:

Skin Rash	Y	N
Persistent Itch	Y	N
Other	_____	

### Musculoskeletal:

Joint Pain	Y	N
Neck Pain	Y	N
Other	_____	

### Respiratory:

Wheezing	Y	N
Other	_____	

PHYSICIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**ACKNOWLEDGEMENT FORM FOR THE FINANCIAL INFORMATION DOCUMENT**

Attached is Garden State Urology Financial Information Document. This document explains the following information:

- In-network financial responsibility
- Out-of-network financial responsibility
- Self Pay / no insurance
- Medicaid/Charity Care
- Collections
- Precertification/authorization

Please take a few moments to read the document and save it with your medical records for future reference.

If you have any questions or concerns after reading the document, please ask to speak to a Financial Counselor.

In order to document for our records that you received this document we require all patients/guarantors to sign below acknowledging receipt of the document.

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I acknowledge receipt of Garden State Urology's Financial Information Sheet that explains the information as outlined above.

Patient/Guarantor Signature \_\_\_\_\_ Date: \_\_\_\_\_

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**For patients with Blue Shield or Horizon Insurance who are seeing an out of network physician:**

Unfortunately, these insurance carriers will not send payment directly to an out of network physician. All payments/ explanations of benefits are sent to the patient/guardian.

**When you receive an explanation of benefit/payment for a service rendered by Garden State Urology contact the Billing Department IMMEDIATELY.**

DO NOT WAIT until you receive a statement or phone call from us.

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**Internal Use Only:**

If patient or patient's representative refuses to sign acknowledgement of receipt of the Payment Summary Sheet, please document the date and time the notice was presented to patient and sign below.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Employee Name: \_\_\_\_\_

G:\GSU BILLING POLICIES\GSU Financial acknowledgment form.doc



**ACKNOWLEDGEMENT OF RECEIPT**

By signing below, I acknowledge that I have been provided a copy of my physician’s Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians and staff.

\_\_\_\_\_  
Print Name of Patient or Patient’s Personal Representative

\_\_\_\_\_  
Signature of Patient or Patient’s Personal Representative

\_\_\_\_\_  
Description of Personal Representative’s Authority

\_\_\_\_\_  
Date

If you have any questions about this notice or would like further information, please contact the Privacy Officer at Garden State Urology, LLC Jeanmarie Falco.

**For office use only:** If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_