PEDIATRIC UROLOGY

Erlanger Main Campus
979 E 3rd St, Ste C-535
Chattanooga, TN 37403
Phone: 423-778-5910

Erlanger East
1755 Gunbarrel Rd, Ste 209
Chattanooga, TN 37421
Phone: 423-778-8478

Erlanger at Parkridge East
961 Spring Creek Rd, St 202
Chattanooga, TN 37412
Phone: 423-778-6941

We would like to welcome you to our practice!

We have an appointment scheduled for: ______________________________

on ______________________ at ______________ with Dr. Paul Zmaj, MD.

Our **Erlanger Main** campus is located inside Erlanger Hospital's Medical Mall. You will take the C-Elevator (next to the pharmacy) to the 5th floor, suite C-535.

Our **Erlanger East** office is located inside the main entrance at Erlanger East Hospital, the one closest to the new Emergency Department. The entrance is on the corner of Crane Rd and Gunbarrel Rd; when you enter the building, the elevator will be on your right, and you will take it to the 2nd floor, suite 209.

Our **Parkridge East** office is located at behind Parkridge East Hospital. Once you are on Spring Creek Rd, you will need to turn down Peck Dr to get to our office building. When you enter the building, you will take the elevator to the 2nd floor, suite 202.

Since this is your first appointment with us, we ask that you arrive 30 minutes before your scheduled appointment time in order to register. For us to see you in a timely manner, please bring the following items and completed forms with you:

- The completed cover letter and packet.
- Parent or guardian's drivers license/photo ID.
- Custody papers or guardianship letters (if applicable).
- Patient's insurance card AND your co-payment (if required by your insurance company). You can pay with check, credit/debit card, or cash. If you do NOT have your insurance card, you will be asked to sign a waiver stating that you are responsible for the full amount of the office visit.

To better service you, if your child has had any imaging (CT, X-ray, Voiding Cystogram, Ultrasound, etc) relevant to their urological condition that was performed OUTSIDE of an Erlanger facility, you will need to bring those films on a disk to this appointment.

If your insurance requires a specialist referral, please guarantee this has been approved and faxed prior to your appointment with us; it is YOUR responsibility to ensure that your child's primary care provider has supplied us with a referral.

Because we have a waiting list to see some of our providers, we require a 24 hour notice to cancel appointments. If we have already closed for the day, please leave a message on our voicemail or with our answering service.

You signature below indicates that you have read and understand the above.

Signature: ____ Date: ____________

This form will be retained in your child's physical or electronic medical chart; we can provide you with a copy at your request.

Pediatric Urology at Erlanger

PATIENT INFORMATION

Patient's First Name:			Middle:		Last:
Street Address:			City:	State:	ZIP Code:
Social Security Number:		Home phone number: ( )		Cell phone number: ( )	
Birth date: / /	Age:	Sex: ☐ M ☐ F	Which is the best number to reach you? ☐ Home ☐ Cell		Pharmacy Name:
Child's Pediatrician:			Pediatrician's office number: ( )		Street your pharmacy is on:
Patient's Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Hawaiian ☐ Native American ☐ Bi-Racial ☐ Other			Patient's Primary Language: ☐ English ☐ Spanish ☐ Other Do you need an interpreter? ☐ Yes ☐ No		

GUARDIAN/RESPONSIBLE PARTY INFORMATION

If you are a foster parent or custodial parent, please list YOUR information

Parent's First Name:	Last Name:			Birth date: / /
Social Security Number:	Marital Status (circle one): Single / Mar / Div / Sep / Wid			Employer:
Employer Address:	City/State:	Zip:		Work Phone Number:

IN CASE OF EMERGENCY

Emergency Contact's Name:	Address:	Relationship:	Phone Number: ( )
Additional Contact's Name:	Address:	Relationship:	Phone Number: ( )

AUTHORIZATION TO OBTAIN TREATMENT

As legal guardian/custodian/representative of the patient listed above, I authorize the following person(s) to obtain medical treatment from Academic Urologists at Erlanger on my behalf in my absence:

Name of Authorized Person:	Relationship to patient:	Phone number: ( )
Name of Authorized Person:	Relationship to patient:	Phone number: ( )

INSURANCE INFORMATION

Please give your insurance card(s) and ID to the receptionist

Name of Primary Insurance:			Policy Number:		Group Number:
Policy Holder's Name:	Birth date: / /		Policy Holder's SSN:		Employer:
Patient's relationship to policy holder:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of Secondary Insurance (if applicable):			Policy Number:		Group Number:
Policy Holder's Name:	Birth date: / /		Policy Holder's SSN:		Employer:
Patient's relationship to policy holder:	☐ Self	☐ Spouse	☐ Child	☐ Other	

RECENT HISTORY

Patient's First Name: | Date of Birth: | Sex: ☐ M ☐ F

Mother's Name (or legal guardian): | Phone Number:

Father's Name (or legal guardian: | Phone number:

Why is your child seeing the doctor today?

List current medications/vitamins and dosages: | List any allergies, especially medications and latex:

Are shots/immunizations up to date: ☐ Yes ☐ No | Pediatrician: | Office Number:

DIETARY HABITS

Describe your child's appetite: ☐ Good ☐ Fair ☐ Poor   Does your child have special nutritional needs? ☐ Yes ☐ No

Does your child have daily bowel movements? ☐ Yes ☐ No
If "no", please explain:

Which of the following are included in your child's diet: ☐ Breast Milk ☐ Formula ☐ Milk ☐ Juice ☐ Tea ☐ Cokes ☐ Fruits ☐ Meats ☐ Vegetables ☐ Grains ☐ Dairy

SPECIAL NEEDS/SAFETY

Does your child have any physical or developmental special needs? ☐ Emotional ☐ Visual ☐ Gross Motor ☐ Language ☐ Hearing ☐ Learning disabilities ☐ Communication problems   If "yes", please explain:

Does your child have a history of abuse or neglect? ☐ Yes ☐ No
If "yes", please explain:

Is your child regularly exposed to second hand smoke? ☐ Yes ☐ No

Does your child use any tobacco products, alcohol, or street drugs? ☐ Yes ☐ No If "yes", please explain:
Does your child have unsupervised pool access? ☐ Yes ☐ No
Do you have guns accessible to children? ☐ Yes ☐ No

PERINATAL HISTORY

What pregnancy was this child? | Mother's age: | Birth Weight: | Delivery Method: ☐ Vaginal ☐ Cesarean Section

During pregnancy, did mom have any of the following: ☐ Bleeding ☐ Diabetes ☐ Rash ☐ Fever ☐ High Blood Pressure
Did your child have any abnormalities on prenatal ultrasounds? ☐ Yes ☐ No If "yes", please explain:

Did your child have any problems at birth: ☐ Yes ☐ No If "yes", please explain:

PATIENT HISTORY

What medications has your child used in the past? Please list them:

Has your child seen a doctor for any of the following conditions? ☐ Allergies ☐ Asthma ☐ Anemia ☐ Cancer ☐ Diabetes ☐ Ear Infections ☐ Strep Throat ☐ Heart Murmur ☐ High Blood Pressure ☐ Mental Disease ☐ Pneumonia ☐ Seizures ☐ Sickle Cell ☐ Kidney Stones ☐ Kidney Infections ☐ Hydronephrosis ☐ Hematuria (blood in urine) ☐ Other (please list)

UROLOGICAL HISTORY

Has your child had bladder, kidney, or urinary tract infections? ☐ Yes ☐ No How often:
Was there a fever associated with these infections? ☐ Yes ☐ No Highest temperature:
Does your child have painful urination: ☐ No ☐ Occasionally ☐ Frequently
Has there been blood in the urine? ☐ No ☐ Yes (on urine test) ☐ Yes (visible)
Is your child toilet trained? ☐ No ☐ Yes What age?
Does your child leak urine during the day? ☐ No ☐ Occasionally ☐ Frequently
Does your child get up at night to urinate? ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently
How often does your child wet the bed? ☐ Never ☐ Occasionally ☐ Frequently
How often does your child have to urinate suddenly? ☐ Never ☐ Occasionally ☐ Frequently
How often does your child urinate during the day?

FAMILY HISTORY

Who lives at home with this child?

Any family members with kidney stones? ☐ Yes ☐ No
Any family members with kidney infections? ☐ Yes ☐ No

Has there been any sibling/parental deaths? ☐ Yes ☐ No If "yes", please explain:
Have any close family members had any of the following? ☐ Allergies ☐ Asthma ☐ Anemia ☐ Cancer ☐ Diabetes ☐ Seizures ☐ Heart Disease ☐ High Blood Pressure ☐ Drug Use ☐ HIV ☐ TB ☐ Stroke ☐ Mental Disease ☐ Kidney Cysts ☐ Sickle Cell ☐ Other (please list)