Orlando Urology Associates, PA

Patient's Name:_____SSN:_____ Age:_____
Street
Address:_____Apt#_____City_____ZIP_____
Date of Birth____/____/_____ Have you been seen here before?_____

Phone: **Home**_____**Work**_____**Cell**_____
E-Mail:_____Employer_____
Emergency contact: **Name**_____**Relationship**_____ **Phone**_____
May we discuss your medical care and financial account with this person?_____

Referring Doctor Information:_____

Is this a work related injury or illness? **Yes**_____**No**_____

Insurance Information

Please provide your cards to the receptionist for copies

Primary Insurance_____

- Are you the primary insured on this plan?**yes**_____**no**_____ If ***not*** please provide the following:
- Primary Insured Name_____Date of Birth_____Phone#_____
- Place of Employment_____Are you a Spouse___Dependent___Other___

Secondary Insurance_____

- Are you the primary insured on this plan?**yes**_____**no**_____ If ***not*** please provide the following:
- Primary Insured Name_____Date of Birth_____Phone#_____
- Place of Employment_____Are you a Spouse___Dependent___Other___

Payment /Financial Policy

It is the policy of this practice that the patients are ultimately responsible for the payment for medical services to the extent allowed by law or regulation. Please remember the insurance company works for you-you pay your premiums to them- and they have no obligation to us except through you as our patient.

- **HMO Patients:** You ***must*** have a referral for our office to be paid by your insurance. If unable to obtain a referral please reschedule your appointment and contact your Primary Care Doctor.
- **Required Co-payments:** Please pay at the time of service. You may receive an additional bill for any applied deductibles as dictated by your specific plan benefits.
- **Payment Options:** Please see one of our billing specialists to make payment arrangements. We accept Visa and Mastercard.
- **Returned Checks:** An additional charge of $15.00 will be added for any returned checks.
- **Credit Bureau:** We will notify you in the form of monthly statements of any outstanding bills. Failure to satisfy the debt will result in your account being reported to the three major credit agencies. Please contact our billing department for payment arrangements.

Assignment of Claims: I hereby instruct my insurance company to make payments directly to ***Orlando Urology Associates*** *for any claim resulting from medical care provided to me. I have read The Payment Policy and my questions have been answered. I agree that a reproduction of this statement and my signature are valid as the original.*

_____

Signature of Patient or Guarantor, if other than patient Date

Notice of Privacy Practices on Reverse Side, Please READ and SIGN

Orlando Urology Associates, PA

Notice of Privacy Practices

April 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Pledge Regarding Medical Information

We understand that information about you and your health is personal. We are committed to protecting that medical information. This notice applies to all of the records of your care generated by Orlando Urology Associates, whether made by your personal physician or our employees.

We are required by law to: make sure your health-related information that identifies you is kept private; give you this notice of our legal duties and privacy practices; and follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information About You

- For Treatment
- For Payments
- Appointment Reminders
- Individuals Involved in Your Care or Payments of Your Care
- As Required by Law
- To Prevent a Serious Threat to Health or Safety

Your Rights Regarding Medical Information About You

You have the following rights regarding the medical information we obtain about you:

- Right to inspect and copy (fee may apply)
- Right to Amend – must be in writing with supporting information
- Right to an Accounting of Disclosures with exception of the following: disclosures you authorize; disclosures to carry out treatment, payment and healthcare operations; and disclosures to persons involved in your healthcare.
- Right to Request Restrictions
- Right to Request Confidential Communications

We reserve the right to make changes to this notice at any time.

Thank You for allowing us to participate in your medical care.

Signature *Date*

Orlando Urology Associates, PA **Account #**_____

Name_____**Date of Birth**_____**Date**_____
Referring doctor_____

History of Present Illness

Chief Complaint: What is the main reason for your visit today?

- **When did you first notice the problem?**_____
- **How long does the problem last?** 30 minutes 1 hour Always there
  Other_____
- **Do any factors make problem worse?** Moving around Standing Up Lying on my side
  Other_____
- **Is the problem constant or variable?** Dull than sharp Very Sharp then Leaves Always There
  Other_____
- **Pain Scale** (1 is least painful; 10 is most painful) **1 2 3 4 5 6 7 8 9 10** or **None**

Past Medical & Social History

Do you now or have you ever had any of the following:

Cancer of the: Kidney_____; Bladder_____; Prostate_____; Testicular_____; Other_____

Frequency of urination problem	_____	**Pain or Burning while urinating**	_____
Strong urgency to urinate	_____	**Frequent Urination at night**	_____
Incontinence (leakage of urine)	_____	**Incontinence** (leakage of stool)	_____
Decreased flow of urination	_____	**Blood in urine**	_____
Difficulty in starting to urinate	_____	**Recurrent urinary infections**	_____

Do you Smoke? _____**For how long?**_____ **How much per day?**_____
Do you drink alcohol ?_____ **How much per day?**_____ **Any other drug use?**_____

Previous Surgeries/hospitalizations

_____
_____
_____

Current Medications: (including regular use of Aspirin):

_____
_____
_____

Pharmacy:
Phone#:_____

Allergies **YES** **NO**

If "yes" please list below

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**.

Please explain any Yes answers in space provided

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other_____

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N

Other_____

Allergic/Immunologic

Hay Fever	Y	N
Drug allergies	Y	N

Other_____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N

Other_____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other_____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Other_____

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Other_____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other_____

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N

Other_____

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N

Other_____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other_____

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N

Other_____

Physician use only: (Comments/Notes)

Physician: _____ Date: ____/____/____