Advanced Urology Associates of Florida

1986 35TH Avenue Vero Beach, FL 32960 (772) 562-7220
7945 Bay St. Suite #4 Sebastian, FL 32958 (772) 388-0239

NEW PATIENT FORM

Dear Patient:

Thank you for choosing our practice for your healthcare needs. Enclosed is an information packet. Please read carefully and complete all applicable areas. All forms must be filled out prior to your appointment. In addition, it is important that you bring your insurance card(s), identification care, co-pay and referral (if required by your insurance).

Appointment Date:_______Arrival Time:______Appt. Time: ______

Office location:

____Vero Beach office
1986 35TH Avenue
Vero Beach, FL 32960
(CORNER OF ROUTE 60 & 35$_{TH}$AVENUE)

_____Sebastian office
7945 Bay Street, Suite 4
Sebastian, FL 32958
(SOUTH OF THE SEBASTIAN RIVER MEDICAL CTR)

REMINDER:

If you do not bring your photo ID, referral, co-pay and insurance card(s) to your appointment, you will be rescheduled. This will only delay your healthcare.

Thank you for your cooperation. We look forward to seeing you.

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REGISTRATON INFORMATION

Date________________________ **SS#**_________________________

Date of Birth_______________ **Sex** ___M ___F **Ethnicity** ___Hispanic/Latino ___ Not Hispanic/Latino

Race ___White ___Black or African American _American Indian/Alaskan ___Asian ___Native Hawaiian

Primary Language_________________ **Martial Status** ___Single ___Married ___Divorced ___Widowed

Patient Name: ____
Last Name First Name MI

Address____City________________St_____Zip__________

Summer/Winter Address__________________________City________________St_____Zip__________

Home Phone__________________ **Cell Phone** ___________________ **Work Phone** _________________

Email____

Primary Physician__________________________ **Referring Physician**___________________________

Pharmacy____________________ **Location**_____________________ **Phone No.**____________________

Emergency Contact __________________________________ **Phone No.**_________________________

Financially Responsible Party_________________________________ **Relationship**_______________

Primary Ins. Co.____ **Policy#**___________________
Policy subscriber Name____ **DOB** _____________________

Secondary Ins. Co.____ **Policy#**___________________
Policy subscriber Name____ **DOB** _____________________

I hereby authorized the Advanced Urology Associates of FL to release any information necessary to process my insurance claim. I also authorized lifetime payment of medical benefits to Advanced Urology Associates of FL.

Patient Signature: ____

Date: _____________________

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MEDICAL HISTORY

Please Print and Fill Out Completely

Name:________________________________Social Security # :______/_____/________

Age:_____Date: ________________ Primary Care Doctor: ________________________

Reason for today's visit:
____

UROLOGIC HISTORY:

Painful Urination_______________Blood in Urine___________Rectal Pain _____________

Chills____________Hesitancy to Start Stream____________Urgency to Urinate _________

Back Pain______________Fevers ________________

Frequent Urination__________________How Often _______________________

How many times do you get up at night to urinate?
____

Is your force of stream:_________Good_________Fair__________Poor

Do you feel you empty your bladder completely?_________Yes__________No Do you

have involuntary leaking of urine?_______________Yes__________No

If yes how does this occur?_____Coughing_____Straining______Sitting______Walking

______Running______In bed at night

When you have the urge to urinate, do you leak before reaching the toilet?_________Yes

_________No

Do you use pads or liners?____Yes_____No If yes, how many each day? __________

Have you ever had Kidney Stones?_________Yes__________No If yes, how often have you had

them? _______________________

Have you ever been told you had a bladder, kidney or prostate problem?____Yes______No

Have you ever had surgery on your_____Kidneys______Penis______Bladder _____

Prostate_____Testicles_____Urethra (water channel)

PERSONAL HISTORY:

Arthritis________Irregular heart beat_______Back problems ________

Joint replacement (which) ___________________

_______Cancer (type) _________________________

_______Mitral valve prolapse

_______Depression

_______Multiple sclerosis

_______Diabetes (how long) __________________

_______Rheumatic fever

_______Glaucoma

_______Stroke (when) _____________________________

_______Heart Murmur (how many) _________________________

_______Heart trouble________Stomach ulcer ____________________________

_______Heart valve replacement/problem

_______High blood pressure

_______Hepatitis

_______Other ____

MEDICATIONS:

Prescription, Over-the-counter, Herbal, Vitamins, or Homeopathic:

____

____

____

____

____

____

ALLERGIES?

____

Date: ____

Date: ____

Date: ____

____

SOCIAL HISTORY:

Do you smoke?______Yes______No If yes, how many packs per day?______

How long have you smoked?________________When did you quit? ___________________

Do you consume alcoholic beverages?______Yes______No

If yes, what type of alcohol? ______________________________

How often? ______________________________________

How much? ____

Do you drink caffeinated beverages? Please list how much every

day: Coffee ____

Tea ____

Colas ____

Chocolate ____

FAMILY MEDICAL HISTORY:

Mother living?________Yes_______No

Mother's current or past medical issues:
____

Father living?________Yes______No

Father's current or past medical issues:
____

Immediate family cancer history? (Grandparents, parents and/or siblings)

____
____
____

Please list any OPERATION, HOSPITALIZATIONS OR SERIOUS ILLNESS:

____ Date: ______________________

____ Date: ______________________

____ Date: ______________________

____ Date: ______________________

____ Date: ______________________

____ Date: ______________________

____ Date: ______________________

SEXUAL HISTORY:

(Males Only)
Do you have difficulty obtaining and maintaining an erection satisfactory for intercourse?
______Yes______No

If yes, please continue with the following.

1. How long has this problem been present? ________________________

2. When was the last date of sexual intercourse (with penetration)?
____

3. Do you ever awaken with an erection?______Yes______No

4. If yes, are they in the morning or at night?

____

5. How full are your erections on a scale from 0 -- 10?

____

6. When you have an erection, is the penis straight or does it curve to one side or the other?
____

7. How long does your erection last?

____

8. Do you satisfy your sexual partner?______Yes______No

9. Have your erection difficulties affected your relationship with your sexual partner? ______

Yes______No

10. Have you seen other physicians for this problem?______Yes______No

11. Have you utilized any treatment for this problem?______Yes______No

12. Do you want to cure this problem?______Yes______No

Advanced Urology Associates of FL

REQUEST FOR CONFIDENTIAL COMMUNICATION

Name______________________________________ **Date of Birth**________________________

Advanced Urology Associates of FL is authorized to release protected information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information: Please mark each person/entity that you approve to receive any personal or medical information	**Description of Information to be Released:** Please mark each **area** of information that may be given to the person/entity listed on the left in the same section.
0 Answering Machine	0 Messages regarding appointments, lab tests/ x-rays or procedures 0 Any other information regarding treatment 0 Any information regarding Medications
0 Spouse (Provide Name and DOB) ____________________	0 Billing Information 0 Financial/ Insurance Information 0 Medical Information (treatments, results, etc)
0 Parents/Children (Provide Name and DOB) ____________________ ____________________ ____________________	0 Billing Information 0 Financial/ Insurance Information 0 Medical Information (treatments, results, etc)
0 Other (Provide Name and DOB) ____________________	0 Billing Information 0 Financial/ Insurance Information 0 Medical Information (treatments, results, etc)

EXPIRATION DATE: Provide an expiration date that this authorization will expire. __ _ _ _ _ _ _ _ _ _ _ _

RIGHTS OF THE PATIENT: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Advanced Urology Associates of FL. I understand that revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

______________________________ ________________
Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority: __ _ _ _ _ _ _ __ _ _ _ _ _ _ _ _ _ _ _ _ _

ACKNOWLEDGEMENT OF PRIVACY NOTICE

In compliance with HIPPA regulations, I have been given the opportunity to review the Joint Privacy Notice for Advanced Urology Associates of FL. I understand a copy of this policy is available for me to take home for my records.

______________________________ ________________
Signature of Patient or Personal Representative Date