FLORIDA UROLOGY PARTNERS, LLP.

PATIENT INFORMATION FORM

FILL IN all **BLANKS Please Print** Appointment Date:____/____/____

Patient Name:

Address:

City: State: Zip: -

Home #: Cell #: Work #: Ext:

E-Mail: **Preferred Contact Method:** Cell or Home Phone E-Mail Mail

Preferred Reminder Method: Cell or Home Phone E-Mail Mail

DOB: / / Age: Sex: **SS#:** - -

Married Single Widow Divorced Separated Other

Race: Asian Black or African American White

Primary Language: English Spanish Other **Ethnic Group:**

Are you currently employed? Yes No

Employer: Occupation:

Address: City State Zip -

Spouse / Guarantor Information

Name: Last First MI

DOB: / / Age: Sex: M F

SS#: - - Daytime Phone #: ( ) -

Cell/Alternate #: ( ) -

Employer: Occupation:

Address: City State Zip

Referred by **Primary Care Physician**

Phone # **Phone #**

Insurance Information

Primary: HMO PPO other list

Guarantor: Self Spouse

Secondary: HMO PPO other list

Guarantor: Self Spouse

Emergency Contact: (*Must be filled out; someone not living with you*)

Relationship: Phone #: ( ) -

Who is responsible for today's visit? Self Insurance other list

How will the visit be paid for today?

I attest that the above information is correct and up to date, if any information changes I understand I need to Contact this office and make the proper changes.

Patient Signature: ______________________________ Date: ____/____/________

FLORIDA UROLOGY PARTNERS, LLP.

CANCELLATION AND NO SHOW FEES

Name: DOB: Age:

To better accommodate our patients, we require at least 24 hours for cancellations; some procedures require 72 hours notice. If we are not notified, a fee will be charged to you, and not your insurance company.

No show/Cancellation less than 24 hour fees are as follows:

Cystoscopy	$75
Routine Visits	$50

No Show/Cancellations less than 72 hour fees are as follows:

Microwave Therapy	$200
Vasectomy	$150
Urodynamics	$100

I have read and understand the cancellation policy.

Patient Name:

Patient Signature: ______________________________Date:______/______/______

FLORIDA UROLOGY PARTNERS, LLP.

Name: DOB: . Age:
Appt Date:_____/_____/_____

Referring PHYSICIAN: ______________________________

Reason for visit: (describe your problem in detail)

____

____

ALLERGIES and reaction to medication:

____

____

List all **MEDICATIONS:**

____

____

____

____

PAST MEDICAL HISTORY: [Check those that apply]

[___] High Blood Pressure
[___] High Cholesterol
[___] Diabetic
[___] Cancer If yes, Type__________________
[___] Vasectomy
[___] Heart Stents
[___] HIV
[___] Hepatitis C
[___] Cardiac Disease If yes, Type__________________
[___] Blood Clots

Other:______________________________

PAST SURGERIES: [Please include type & date]

____

____

____

____

FAMILY HISTORY: [Check those that apply & add family member]

	Family Member
[___] Prostate Cancer	____________
[___] Diabetic	____________
[___] Cancer If yes, Type__________________	____________
[___] Cardiac Disease If yes, Type__________________	____________
[___] Kidney Stones	____________
[___] High Blood Pressure	____________
Other: ______________________________	____________
______________________________	____________

SOCIAL HISTORY: [__]Married [___]Single [___]Divorced [___]Widowed [___]Separated [___]Other____________

Tobacco use: [___]Yes [___]No if yes, How Much: ________________ Date Quit: _______/_______/_________

Alcohol Use: [___]Yes [___]No If yes, frequency: ________________ Type__________________

OCCUPATION: ______________________________

Physician Use Only:

____

____

____

____

____

FLORIDA UROLOGY PARTNERS, LLP.

HIPAA PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- ✓ The patient understands that:
- ✓ Protected health information may be disclosed or used for treatment, payment or health care operations.
- ✓ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- ✓ The Practice reserves the right to change the Notice of Privacy Policies.
- ✓ The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- ✓ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- ✓ The practice may condition treatment upon the execution of this consent.

Patient: DOB: ge: Account #:

This Consent signed by: Patient Signature:______________________________ Date: ____/____/________

Other Name: ______________________ Relationship to Patient: ____________________

Signature:______________________________ Date: ____/____/________

Family members or other persons, if any, we may inform of your general medical condition and diagnosis (including treatment, payment, and healthcare operation):

Name: ________________________________ Phone #: [______] ________/____________

Name: ________________________________ Phone #: [______] ________/____________

Name: ________________________________ Phone #: [______] ________/____________

Please list family members or other persons, if any, we may inform of your general medical condition **ONLY IN EMERGENCY:**

Name: ________________________________ Phone #: [______] ________/____________

Name: ________________________________ Phone #: [______] ________/____________

Address for billing and/or correspondence if other than your home: Name: ______________________________

______________________________City____________________State__________Zip____________

Phone # where you want to receive calls about appointments, lab or x-ray test, or other health care information.

[______]________/____________ [______]________/____________ [______]________/____________

Would you like all correspondence marked "Personal and confidential"? _____Yes _____No

Can confidential messages be left on your telephone voicemail? _____Yes _____No

FLORIDA UROLOGY PARTNERS, LLP.

LIFETIME SIGNATURE FORM

(May be withdrawn by subsequent notice)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to **FLORIDA UROLOGY PARTNERS, LLP** for the surgical and/or medical benefits and I understand that I am financially responsible for charges not paid by my insurance company or Medicare.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize **Malcolm Root, M.D., Howard B. Heidenberg, D.O., Raviender Bukkapatnam, M.D., Mohamed Helal, M.D., Salim Afridi, M.D.** and/or **Mohit Sirohi, M.D.**the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the release of information to **Malcolm Root, M.D., Howard B. Heidenberg, D.O., Raviender Bukkapatnam, M.D., Mohamed Helal, M.D., Salim Afridi, M.D.** and/or **Mohit Sirohi, M.D.** from any hospital(s) and/or physician(s) including the diagnosis and records of my treatment and/or examination.

Authorize photocopies of this form to be valid as the original:

Patient: DOB: Age:

Patient: Signature: ______________________________ Date: ____/____/________

Parent of Minor: (please print name) First ____________________ Last ____________________

Signature: ______________________________ Date: ____/____/________

Guarantor: (please print name) First ____________________ Last ____________________
(Other than patient)

Signature: ______________________________ Date: ____/____/________

As a friendly reminder, it is the policy of this practice that payment for services rendered in the office is due and expected at the time of the visit. This includes all co-payments that we are contractually obligated to collect.

Thank you for your cooperation.

FLORIDA UROLOGY PARTNERS, LLP.

Male Questionnaire

Appt. Date:___/___/___ Account#:

DOB:

Patient Name: Age:

Take these tests to find out about 2 common conditions.

You may feel embarrassed to talk to your doctor about urinary problems. But, like gray and thinning hair, such problems are a part of aging. One of the causes of urinary symptoms in men over 50 is a treatable condition called benign prostatic hyperplasia (BPH). In fact, it has been estimated that by the age of 80, 1 in every 4 males in the US will require treatment of their urinary symptoms caused by BPH.

Take this quiz to help you and your doctor decide whether you could benefit from a BPH treatment.

Taking the quiz:

Please **circle** the answer that best represents your response to each of the following question. The questions are designed to gauge the severity of any symptoms you may be experiencing.	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Patient score
1. **Incomplete Emptying:** Over the past month, how often have you had a sensation of not emptying your bladder completely after you have finished urination?	0	1	2	3	4	5	
2. **Frequency:** Over the past month, how often have you had to urinate again less than 2 hours after you have finished urinating?	0	1	2	3	4	5	
3. **Intermittency:** Over the past month, how often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5	
4. **Urgency:** Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. **Weak Stream:** Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. **Straining:** Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	
7. **Nocturia:** 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	1	2	3	4	5+	

Your Total Score _____

Quality of Life due to Urinary Symptoms	**Delighted**	**Pleased**	**Mostly Satisfied**	**Mixed**	**Mostly Dissatisfied**	**Unhappy**	**Terrible**
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Scoring the Quiz:

Add the numbers from your answers to question 1 through 7. The maximum possible score is 35. The final question will help you judge how you feel about your symptoms.

Please Note: This test is used to measure the severity of your symptoms. It is not a diagnostic test. In other words, it will not tell you whether or not you have BPH. Talk to the doctor to determine whether your symptoms are due to BPH.

FLORIDA UROLOGY PARTNERS, LLP.

Male Questionnaire

Appt. Date:___/___/___

Patient Name:

Account#:

DOB:

Age:

Start a conversation with your doctor about low testosterone (Low T).

This self-test is a good place to begin.

Answer **Yes** or **No** to the following questions	**YES**	**NO**
1. Do you have a decrease in libido (sex drive)?	_____	_____
2. Do you have a lack of energy?	_____	_____
3. Do you have a decreased in strength and/or endurance?	_____	_____
4. Have you lost height?	_____	_____
5. Have you noticed a decreased "enjoyment of life"?	_____	_____
6. Are you sad and/or grumpy?	_____	_____
7. Are your erections less strong?	_____	_____
8. Have you noticed a recent deterioration in your ability to play sports?	_____	_____
9. Are you falling asleep after dinner?	_____	_____
10. Has there been a recent deterioration in your work performance?	_____	_____

If you answered **YES to** questions **1** or **7** or **any 3 other questions**, you may have low testosterone. A simple blood test can determine your testosterone level. Talk with the doctor to find out if testosterone replacement therapy can help you.

FLORIDA UROLOGY PARTNERS, LLP.

PHARMACY INFORMATION

Patient Name: DOB:

We need this information to complete your records per government regulations

Please CIRCLE Pharmacy Name
And Fill out pharmacy Phone address etc on bottom

Most Common Pharmacy	Other Pharmacy	
CVS	Albertsons Sav-On Drugs	Idel
Davis Island	AmeriDrug	Kabs
K-Mart	Bearss	Kings Drugs
MacDill	Carrollwood	Memorial Family
MacDill AFB	College Hill Pharmacy	Northdale
Medco	David's	Royal Rx
Publix	Extra Care	Shaw's Osco
Sam's Club	F&B Drugs	South Tampa
Sweetbay	Fletcher Medical Center	St. Joseph Hospital
Target	Florida Discount	Superior
Walgreens	Habana	Tampa bay Professional
Walmart	Healthlink	Tampa Drugs & Diabetic center
West Shore	Healthwise	TGH Tampa General Hospital
Winn-Dixie	Hills	The Drug Shoppe
		University Drugs
Pharmacy not listed		VA Hospital
Name ____________________		West Coast

We need the following information to add your **pharmacy** to the computer

Address, Street name or Street corners ____________________

City Circle if Tampa if not list City ____________________

Phone # ____________________

Thank You for your help