UROLOGY ASSOCIATES OF SOUTH FLORIDA

MARK R. LICHT, M.D. ANGELOS N. MANGANIOTIS, M.D.

Name:_____ Cell Phone #_____

Address:_____Apt #____ Home phone#_____

City_____State:_____ Zip:_____ Work phone#_____

Birth Date:_____Age:____ Male/Female:_____Soc. Sec.#_____

Patient E-MAIL:_____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Alternate Address:_____Alt. Phone#_____
(Up North)
City:_____State:_____ Zip:_____

Name of Employer:_____Marital Status:_____

Spouse's Name:_____

Name, Address & Phone # of emergency contact (not living with you):_____
_____

Primary Physician:_____
Please provide us with the following insurance information as well as your insurance cards: Primary Ins:_____Secondary Ins:_____

I have been offered a copy of Urology Associates of South Florida's Notice of Privacy Practices.

Authorization and Assignment

I certify that the above information is correct and accurate. I hereby authorize Urology Associates of South Florida to release any information acquired during my examination to my insurance companies and other treating physicians. I further authorize payment directly to Urology Associates of South Florida for services rendered. I understand and accept that I am financially responsible to Urology Associates of South Florida for all deductibles and fees not covered by my insurance. In the event that I have no insurance or my insurance is rejected, I understand I am responsible for all fees incurred. If my insurance requires authorization from my primary care physician, I understand that is my responsibility to obtain such authorization and that I will be responsible for all fees incurred if authorization is not obtained. I also understand that payment is expected at the time services are rendered.

Patient signature:_____**Date:**_____

UASF History and Intake Form

Patient Name:_____ Date:_____
DOB: _____ Age:_____

What are you here for today? _____
_____
_____
_____

Whom may we thank for referring you? _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplant
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Heart Attack
NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Hernia (Right, Left)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Pacemaker
Spinal Surgery

NONE

Other _____

Urology Disease History: (please circle all that apply)

Prostate Nodule	Prostatitis
Cancer (Bladder)	Renal Insufficiency
Cancer (Kidney)	Renal Tubular Acidosis
Cancer (Penile)	Sexual dysfunction
Cancer (Prostate)	Sexually transmitted disease
Cancer (Testicular)	Genitourinary trauma
Cystinuria	Tuberculosis
Elevated PSA	Tuberous Sclerosis
Hematuria	Undescended testis
Hydronephrosis	Urethral Stricture
Infertility	Urinary Incontinence
Kidney Stones	Urinary Retention
Neurogenic Bladder	Urinary Tract Infection
Polycystic Kidney Disease	Vesicoureteral Reflux (VUR)
Priapism	Von Hippel Lindau

Other _____

Medications: (Please enter all current medications)

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Never smoked
Former Smoker

Alcohol Use:

EtOH – None
EtOH – less than 1 drink per day
EtOH – 1-2 drinks per day
EtOH – 3 or more drinks per day

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other	Y	N

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other	Y	N

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other	Y	N

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/ Tingling	Y	N
Other	Y	N

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/ Sluggish	Y	N
Other	Y	N

Gastrointestinal

Abdominal Pain	Y	N
Indigestion/ Heartburn	Y	N
Other	Y	N

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other	Y	N

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other	Y	N

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other	Y	N

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other	Y	N

Genitourinary Y N

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other		

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problems	Y	N
Other	Y	N

Psychological

Are you generally unsatisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other	Y	N

Other _____

Family History (Only first degree relatives)

_____

_____

_____

_____

Preferred Language: _____

Race:_____ **Ethnic Group:**_____

Preferred Pharmacy Name: _____

Phone#: _____

City:_____

Zip code:_____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Other Symptoms: _____

ALERTS	**YES**	**NO**
Premedication prior to procedures	☐	☐
Rapid heartbeat with epinephrine	☐	☐
Pregnancy or planning a pregnancy	☐	☐
West Africa: Travel or Contact	☐	☐
Ebola Risk: Resided or Traveled To Country with wide-spread Ebola Transmission in the last 21 days	☐	☐
Ebola Risk: Contact with an Ebola Patient without proper protective equipment in the last 21 days	☐	☐
Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, Abdominal pain and/or hemorrhage	☐	☐
Ebola Risk: Fever >= 100.4 degrees (F) / 38.0 degrees (C)	☐	☐

SIGNING THE HIPAA CONSENT: By signing you are consenting to allow Urology Associates of South Florida to use and disclose your "Protected Health Information" to carry out treatment, to order testing and to procure payment and for health care reasons as outlined in the above document.

Release of Medical Information, Authorization and Payment:

I hereby authorize Urology Associates of South Florida to release Health Care Information about me to secure payment from my insurance company and also authorize payment directly to Urology Associates of South Florida. I recognize and accept personal responsibility for payment of any non-covered or unauthorized services.

Community Exchange of Information:

Our Electronic Medical Records Software will allow us to exchange your personal health information with other offices and Boca Regional Hospital clinical staff. We feel this is an important aspect of using electronic data to improve your medical care. If another physician, lab technician, or nurse, for example, needs information regarding your medical history they can access it through this system. This exchange is subject to the same rigid rules and regulations that apply to your personal health information in this office. Non-compliance may subject users to severe penalties or loss of employment. By signing below you agree to this Community exchange of your healthcare information. If you wish to opt out of this, you must check the box below.

Medicare Patients Only:

I certify that the information I have provided in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any medical provider to release necessary information to the Social Security Administration or its intermediaries for Medicare claims. I agree to the payment of authorized benefits to Urology Associates of South Florida on my behalf. (I may opt out of this release, but will then be obligated to pay directly and for my medical care.)

Signed _____

Date _____

If patient is a Minor Signature of Guardian _____

☐ I wish to **OPT OUT** of the Community Exchange Information. (You must notify staff of this request so that the appropriate steps will be taken to exclude your health information.)

Urology Associates of South Florida
7280 W. Palmetto Park Rd.
Suite 305
Boca Raton, FL 33433

(Name of Practice)

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  _____
- ☐ Other: _____

  _____

Prepared By _____

Signature _____

Date _____