Oceanside Urology, LLC

Daniel J. Caruso, MD ☐
Kaveh Besharat, MD ☐
F. Andrew Celigoj, MD ☐

Consent for Treatment

Patient's name: ___________________________

I,_______________________, agree and consent to participate in health care services offered and provided by Oceanside Urology, LLC. If the patient is under the age of eighteen (18) or unable to consent to treatment, I attest that I have legal custody of the above named individual and I am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

X______________________________ __________________
Signature Date

____
Relationship to patient

221 Greenwich Circle, Suite 107
Jupiter, Florida 33458
Phone: 561-746-9227
Fax: 561-746-9221

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Please read carefully. Responsible parties whose signatures appear below agree as follows:

The responsible parties agree to pay to Oceanside Urology, LLC, for all fees and charges for supplies, services and treatment that are incurred by the patient. It is the responsibility of the responsible parties to know his/her health benefits. Therefore, responsible parties are strongly advised to monitor and communicate with his/her Health Insurance Company to ensure that Doctor's claims are paid promptly, since they, as responsible parties, are ultimately financially responsible for all amounts owed to Oceanside Urology, LLC. It is important that you know that not all services and/or fees are covered or paid for by the Responsible Parties' Health Insurance Company; therefore, the Responsible Parties agree to pay for all deductibles, copayments, non-covered services, and any portion of covered services not paid in full by the Plan. Depending on the patient's Health Insurance Plan, payments are due at the time of service or immediately upon presentation of the bill. There are no other agreements, promises, representations or warranties, expressed or implied to substitute this agreement.

Agreed to and accepted by the Responsible Parties.

X:__________________________________ _____/____/_____

Signature Date

____

Printed Name

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DEMOGRAPHICS

DATE: ______/_______/________

NAME: ________________________________D.O. B: ______/______/_____ (SEX: M / F)

ADDRESS: ____

CITY: ___________________________ STATE: _____________ ZIP CODE: _________

HOME PHONE: (_____) _____-_________ CELL PHONE: (____) ______-_________
Can we text you at the cellphone number listed regarding your healthcare and future appointments? Y / N

SOCIAL SECURITY #: ______-______-_______

PRIMARY INSURANCE COMPANY: _______________________ MEMBER ID #: _____________
SECONDARY INSURANCE COMPANY: _____________________ MEMBER ID #: _____________

PRIMARY CARE DOCTOR: ____

WHO REFERRED YOU TO US? ____

EMAIL ADDRESS: ______________________________@_______________________________

EMERGENCY CONTACT

NAME: ________________________________ PHONE: _____________________________

RELATION: ______________________________

I GIVE THIS PERSON PERMISSION TO DISCUSS MY HEALTH INFORMATION? ☐YES ☐NO

PHARMACY

NAME: ___________________________________ PHONE: ______________________

LOCATION: ____

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FEMALE

Oceanside Urology, LLC

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Patient Name: ______________________

-INTAKE-

What is the reason for your visit today? (Please describe in detail)

____
____
____
____

For How Long?____________Degree of Severity:1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10☐

-MEDICAL HISTORY-

If none of this applies, please do not leave blank. Please write N/A.

PAST MEDICAL HISTORY

____
____
____
____
____
____
____
____

CURRENT MEDICATIONS

____
____
____
____
____
____
____
____

PAST SURGICAL HISTORY

____
____
____
____
____
____
____

MEDICATION ALLERGIES (including iodine)

____
____
____
____
____
____
____

FAMILY MEDICAL HISTORY

____
____
____
____

OB/GYN HISTORY

How many children do you have? ______
How many pregnancies? ______
How many C-sections? ______
Last menstrual period? ______

SOCIAL HISTORY

Do you smoke: _________
How many packs per day? _________
How many years? _________
When did you quit? _________
Do you drink alcohol? _________
How many drinks per week? _________
When did you quit? _________
Do you use any illicit drugs? _________

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FEMALE

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- Review of Systems-

Yes	No	Constitutional
☐	☐	Unwanted weight loss
☐	☐	Fever (last 72 hours)
☐	☐	Chills (last 72 hours)

Yes	No	HEENT
☐	☐	Change in vision
☐	☐	Problems swallowing
☐	☐	Glaucoma

Yes	No	Cardiovascular
☐	☐	History of blood clots
☐	☐	Chest pain (last 72 hours)
☐	☐	Palpitations (last 72 hours)
☐	☐	Dizziness (last 72 hours)

Yes	No	Endocrine
☐	☐	Excessive thirst
☐	☐	Heat/cold intolerance
☐	☐	Hot Flashes

Yes	No	Respiratory
☐	☐	Frequent cough
☐	☐	Short of breath (last 72 hours)
☐	☐	Wheezing (last 72 hours)

Yes	No	Gastrointestinal
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Rectal bleeding

Height:__________(ft)_______(in)
Weight: _______(lbs)

Yes	No	Psychiatric
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Suicidal ideation

Yes	No	Genitourinary
☐	☐	Pain while urinating
☐	☐	Burning while urinating
☐	☐	Blood in urine
☐	☐	Hesitancy in going
☐	☐	Incontinence
☐	☐	Retention of urine
☐	☐	Urgency to urinate
☐	☐	Pain with intercourse
☐	☐	Weak urinary stream
☐	☐	Strain to urinate
☐	☐	Bladder/kidney infections
☐	☐	Frequency of urination

Yes	No	Musculoskeletal
☐	☐	Joint pain
☐	☐	Neck pain
☐	☐	Back pain

Yes	No	Neurological
☐	☐	Strokes
☐	☐	Seizures
☐	☐	Tremors

Yes	No	Skin
☐	☐	Rashes
☐	☐	Jaundice
☐	☐	Boils

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IT'S TIME TO TALK ABOUT OAB

Think You Have Overactive Bladder?

Do you think you have Overactive Bladder? Millions of men and women live with Overactive Bladder. This quiz will help you measure which Overactive Bladder (OAB) symptoms you have and how severe those symptoms are. Base your answers on the past month.

(Circle the response that best answers each question)

Symptom Questions	Not at all	Occasionally	About once a day	About three times a day	About half the time	Almost always	SCORE
1. Urgency – How often do you have a strong, sudden urge to urinate that makes you fear you will leak urine if you can't get to a bathroom immediately?	0*	1	2	3	4	5	
2. Urgency Incontinence – How often do you leak urine after feeling an urge to go? (whether you wear pads/ protection or not)	0	1	2	3	4	5	
	None	Drops	1 Tea-spoon	1 Table-spoon	¼ cup	Entire bladder	
3. Incontinence – How much urine do you think usually leaks? (whether you wear pads/ protection or not)	0	1	2	3	4	5	
	1-6 times	7-8 times	9-10 times	11-12 times	13-14 times	15 or more times	
4. Frequency – How often do you urinate during the day?	0	1	2	3	4	5	
	None	1 time	2 times	3 times	4 times	5 times or more	
5. Wake to urinate – How many times do you usually get up each night to urinate, from when you went to bed until you got up in the morning?	0	1	2	3	4	5	

TOTAL SYMPTOM SCORE (Add score from questions 1+2+3+4+5) =

0 = no symptoms

25 = most severe symptoms

*If you score 0 on question 1, you probably don't have OAB.

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