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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MALE

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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

_____
_____
_____
_____
_____
_____
_____

UROLOGIC HISTORY

Yes	No	
☐	☐	Prostate biopsy/surgery
☐	☐	Elevated PSA
☐	☐	Prostate cancer
☐	☐	Kidney stones
☐	☐	Kidney/Bladder cancer

MEDICATION ALLERGIES (including iodine)

_____
_____
_____
_____
_____
_____

PAST SURGICAL HISTORY

_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

☐yes☐no Family hx of prostate cancer?

_____
_____
_____

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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MALE

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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

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
☐	☐	Difficulty with erections
☐	☐	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

Height:_____(ft)_____(in)
Weight: _____(lbs)

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MALE

Urology Care FOUNDATION™
The Official Foundation of the American Urological Association

AMERICAN UROLOGICAL ASSOCIATION (AUA) SYMPTOM SCORE

Have you noticed any of the following when you have gone to the bathroom to urinate over the past month? Circle the correct answer for you and write your score in the right hand column. **Talk with a health care provider if your total score on the first seven questions is 8 or greater or if you are bothered at all.**

	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	Your Score
Incomplete emptying – It does not feel like I empty my bladder all the way.	0	1	2	3	4	5	
Frequency – I have to go again less than two hours after I finish urinating.	0	1	2	3	4	5	
Intermittency – I stop and start again several times when I urinate.	0	1	2	3	4	5	
Urgency – It is hard to wait when I have to urinate.	0	1	2	3	4	5	
Weak stream – I have a weak urinary stream.	0	1	2	3	4	5	
Straining – I have to push or strain to begin urination.	0	1	2	3	4	5	
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 times or more**	**Your Score**
Nocturia – I get up to urinate after I go to bed until the time I get up in the morning.	0	1	2	3	4	5	

Total AUA Symptom Score

Total score: 0-7 mild symptoms; 8-19 moderate symptoms; 20-35 severe symptoms

Quality of life due to urinary symptoms							
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?	Delighted	Pleased	Mostly satisfied	Mixed: about equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible