Michael P. Zahalsky, MD - Mini Varghese, MD - Christopher P. Hollowell, MD - Justin A. Muskovich, MD
Melissa Marchand, PA-C - Monika Kulik, PA-C - Jacquelyn White, PA-C
954-714-8200 Phone 954-840-2626 Fax
www.zurology.com

PERSONAL INFORMATION

PATIENT NAME:_____ DOB _____ SS# ____-____-____

ADDRESS: _____

HOME PHONE: _____CELL PHONE _____WORK PHONE _____

EMAIL: _____ *PRIMARY LANGUAGE:* _____

RACE: _____ *ETHNICITY:* _____ *PHARMACY NAME /PHONE:* _____

SEX: MALE _____ FEMALE _____ MARITAL STATUS _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP:_____

ADDRESS: _____

HOME PHONE: _____CELL PHONE _____WORK PHONE _____

OCCUPATION: _____ EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

HEALTH INSURANCE

PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD AND PHOTO IDENTIFICATION

PRIMARY COMPANY: _____ SECONDARY COMPANY: _____

ID # _____GROUP # _____ ID # _____GROUP # _____

GUARANTOR NAME (PERSON TO BILL IF OTHER THAN PATIENT) _____

ADDRESS: _____

HOME PHONE: _____CELL PHONE _____WORK PHONE _____

EXTENDED AUTHORIZATION AND CONSENT

I request that payment under the medical insurance program be made directly to the above named provider on any unpaid bills for services on or after the date indicated below. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers of insurance companies, any information needed for this or related Medicare or Insurance claim. I understand that I am financially responsible for services rendered regardless of my insurance status. I also understand that I am financially responsible for all and /or referring physicians when required. I permit a copy of this authorization to be used in place of the original. Should this account go to collections I will be responsible for all costs of collection and/or attorneys fees. I FURTHER ACKNOWLEDGE THE OFFICE "NO SHOW" POLICY. IF I FAIL TO NOTIFY THE OFFICE WITHIN 24 HOURS BEFORE MY SCHEDULED APPOINTMENT I WILL BE CHARGED $75.00. THIS IS AN UNCOVERED INSURANCE ITEM I WILL BE RESPONSIBLE FOR PAYMENT.

SIGNATURE OF PATIENT: _____ DATE: _____
or Signature of Guardian

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NAME: _____ DATE OF BIRTH: _____

List of Reasons for today's visit: _____

MEDICAL HISTORY

Prior Illnesses and Serious Injuries: _____

_____

Prior Surgeries: _____ Date _____

Prior Surgeries: _____ Date _____

Prior Hospitalizations: _____ Date _____

Prior Hospitalizations: _____ Date _____

Please list all the medications you are currently taking: _____

_____

Allergies and Reactions (Drug, Food, Or Other) : _____

Sexually Transmitted Diseases: _____

FAMILY MEDICAL HISTORY

Urology Disease (i.e. Kidney stones, incontinence) ___mother _____father_____other: _____

Please Specify :_____

Cancer _____mother _____father _____other: _____ Please Specify :_____

Social History

Marital Status: _____Single _____Married _____Divorced _____Widowed _____Cohabitating

Living Situation _____Living at Home _____Nursing Home _____Homeless _____Other

Occupation: _____

Tobacco Use: ____Non Smoker ____ Smoker: Packs Per Day: _____

Alcohol Use: ____Non Drinker ____Yes, I Drink _____Ounces Per day

Drug Use: ____Non User ____User Type: _____

NAME: _____ DOB: _____

UROLOGY

PLEASE COMPLETE BUBBLE SHEET THOROUGHLY

Urology

Frequent urination	O Yes O No
Urgent need to urinate	O Yes O No
Pain with urination	O Yes O No
Nighttime urination	O Yes O No
Difficulty starting urinary stream	O Yes O No
Leakage or dribbling	O Yes O No
Reduced flow	O Yes O No
Blood in urine	O Yes O No
Straining to urinate	O Yes O No
Pelvic pain	O Yes O No
Sexual difficulty	O Yes O No
Female-infertility	O Yes O No
Female-irregular periods	O Yes O No
Female- vaginal discharge	O Yes O No

Other: _____

Male Reproductive

Difficulty with erection	O Yes O No
Difficulty with ejaculation	O Yes O No
Diminished sexual drive	O Yes O No

Other: _____

Cardiology

swelling of feet, ankles, or hands	O Yes O No
shortness of breath	O Yes O No
chest pain at rest	O Yes O No
Chest pain with exertion	O Yes O No
Dizziness	O Yes O No
Irregular heartbeat	O Yes O No
Palpitations	O Yes O No

Other: _____

Dermatology

Scars	O Yes O No
Rash	O Yes O No
Dry or Sensitive Skin	O Yes O No
Hives	O Yes O No
Acne	O Yes O No
Skin cancer	O Yes O No

Other: _____

Endocrinology

Fatigue	O Yes O No
Excessive Thirst	O Yes O No
Excessive Urination	O Yes O No
Cold Intolerance	O Yes O No
Hot flashes	O Yes O No
Weight Loss	O Yes O No

Other: _____

ENT

difficulty swallowing	O Yes O No
Sore throat	O Yes O No
Cough	O Yes O No
Sinus Problems	O Yes O No
hearing loss/hard of hearing	O Yes O No
nose bleeds	O Yes O No
Tinnitis (ringing in ear)	O Yes O No

Other: _____

Gastroenterology

black/tarry stools	O Yes O No
diarrhea	O Yes O No
abdominal pain	O Yes O No
nausea/vomiting	O Yes O No
Heartburn / indigestion	O Yes O No
blood in stool	O Yes O No
Constipation	O Yes O No

Other: _____

General

fever	O Yes O No
Chills	O Yes O No
fatigue	O Yes O No
weakness	O Yes O No
weight loss	O Yes O No
weight gain	O Yes O No

Other: _____

Hematologic/Lymphatic

excessive bleeding w/dental work	O Yes O No
easy bruising	O Yes O No
swollen glands	O Yes O No
loss of appetite	O Yes O No

Other: _____

Musculoskeletal

fracture	O Yes O No
back pain	O Yes O No
Bone pain	O Yes O No
Muscle weakness	O Yes O No
Joint swelling, stiffness, pain	O Yes O No

Other: _____

Neurology

Insomnia	O Yes O No
Dizziness	O Yes O No
Weakness	O Yes O No
Headache	O Yes O No
Numbness	O Yes O No
Seizures/Convulsions	O Yes O No
Leg weakness	O Yes O No

Other: _____

Ophthalmology

blurring of vision	O Yes O No
eye drainage	O Yes O No
eye irritation, pain	O Yes O No
loss of vision	O Yes O No
Spots in vision	O Yes O No

Other: _____

Respiratory

Shortness of breath	O Yes O No
Need for home oxygen	O Yes O No
Chest pain	O Yes O No
Cough	O Yes O No
Chronic/Frequent cough	O Yes O No
Difficulty breathing at rest	O Yes O No
Difficulty breath on exertion	O Yes O No

Other: _____

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HIPAA Authorization

PATIENT'S FULL NAME_____

SOC SEC #_____ BIRTHDATE_____ PHONE _____ E-MAIL_____

STREET _____STATE ____ ZIP _____

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) _____ will not release confidential health information, either in person or by telephone, email, or fax to any unauthorized people. When returning telephone calls, we will not leave a message on an answering machine or voicemail unless we are authorized in writing to do so. Also, information will not be given to an unauthorized person who may answer your telephone (either at home or at work).
If you would like to authorize us to release medical information to someone other than yourself or to leave information on a recording device, please complete the following:

I authorize _____to release confidential medical information pertaining to my care by the following methods and to the following people. I understand that it is my responsibility to notify Z Urology if this authorization information changes.

It is ok to leave confidential medical information for me on my:
[] Home telephone/message _____
[] Work telephone _____
[] Mobile telephone _____
[] Home Facsimile _____
[] Work Facsimile _____

It is okay to give confidential medical information to my:
(List specific names)
[] Spouse _____
[] Parent(s) _____
[] Son/daughter _____
[] Brother/Sister _____
[] Other (name required) _____

I authorize this information to be disclosed in the following ways:
[] Written/photocopy/paper _____
[] Verbal _____
[] Facsimile _____

Dates of treatment: From _____ to:_____

Specific description of the protected health information that I authorize for disclosure
(Authorization to disclose psychotherapy notes must be separate):
[] Progress notes
[] X-ray films or other images
[] Radiology reports
[] Operative reports
[] Discharge summary
[] Laboratory reports
[] Photographs/videotapes
[] Records from other facilities
[] Entire health records, (including, but not limited to information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities).
[] Other

I give specific authorization to disclose the following information:
[] HIV test results
[] Documentation of AIDS diagnosis
[] Psychiatric/mental health treatment records

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Please indicate/describe each authorized purpose of the use or disclosure:
[] At the request of the individual (patient)
[] Other

_____
_____
_____
_____

I understand that this authorization will automatically expire in 6 months unless otherwise specified: _____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Relationship or Authority of Personal Representative (if applicable)_____

Signature of Legal Representative: _____ Date: _____

Print Name: _____

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HIPAA CONSENT

Patient Consent for use and Disclosure of Protected Health Information

With my consent, **Z Urology** May use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Z Urology Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

I understand that **Z Urology** reserves the right to revise its Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, **Z Urology**, 5850 Coral Ridge Drive, Suite 106, Coral Springs, FL 33076.

With my consent, **Z Urology** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Z Urology** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Z Urology** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Z Urology** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form I am consenting to **Z Urology** use and disclosure of my PHI to carry out TPO.

At any time, I may revoke my consent in writing, by sending a signed and dated written statement to Privacy Officer, **Z Urology**, 5850 Coral Ridge Drive, Suite 106, Coral Springs, FL 33076, saying that I am revoking my authorization to disclose health records, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent **Z Urology** may decline to provide treatment to me.

Patient's Name (Printed) _____

Signature (of Parent or Legal Guardian for Minors)_____

Parent or Legal Guardian Name (Printed) _____

Relationship or Authority of Personal Representative (if applicable)_____

Date_____

If patient is less than 18 years of age, or can't legally sign for himself/herself, his/her parent's or legal guardian's signature is required.