



Michael P. Zahalsky, MD - Mini Varghese, MD - Christopher P. Hollowell, MD - Michael Tyler, MD
Melissa Marchand, PA-C - Monika Kulik, PA-C - Linda Calderon, PA-C
954-714-8200 Phone 954-840-2626 Fax
www.zurology.com

PERSONAL INFORMATION

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

HOW DID YOU HEAR ABOUT US? (please circle one and provide the referral source so we may thank them):

Friend / Doctor / Internet Search / Social Media / Website / Media / Other: _____

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 ___ Cohabiting

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: _____

PLEASE COMPLETE BUBBLE SHEET THOROUGHLY**Urology**

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

Male Reproductive

- Difficulty with erection Yes No
Difficulty with ejaculation Yes No
Diminished sexual drive Yes No
Other: _____

Cardiology

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

Dermatology

- Scars Yes No
Rash Yes No
Dry or Sensitive Skin Yes No
Hives Yes No
Acne Yes No
Skin cancer Yes No
Other: _____

Endocrinology

- Fatigue Yes No
Excessive Thirst Yes No
Excessive Urination Yes No
Cold Intolerance Yes No
Hot flashes Yes No
Weight Loss Yes No
Other: _____

ENT

- difficulty swallowing Yes No
Sore throat Yes No
Cough Yes No
Sinus Problems Yes No
hearing loss/hard of hearing Yes No
nose bleeds Yes No
Tinnitus (ringing in ear) Yes No
Other: _____

Gastroenterology

- black/tarry stools Yes No
diarrhea Yes No
abdominal pain Yes No
nausea/vomiting Yes No
Heartburn / indigestion Yes No
blood in stool Yes No
Constipation Yes No
Other: _____

General

- fever Yes No
Chills Yes No
fatigue Yes No
weakness Yes No
weight loss Yes No
weight gain Yes No
Other: _____

Hematologic/Lymphatic

- excessive bleeding w/dental work Yes No
easy bruising Yes No
swollen glands Yes No
loss of appetite Yes No
Other: _____

Musculoskeletal

- fracture Yes No
back pain Yes No
Bone pain Yes No
Muscle weakness Yes No
Joint swelling, stiffness, pain Yes No
Other: _____

Neurology

- Insomnia Yes No
Dizziness Yes No
Weakness Yes No
Headache Yes No
Numbness Yes No
Seizures/Convulsions Yes No
Leg weakness Yes No
Other: _____

Ophthalmology

- blurring of vision Yes No
eye drainage Yes No
eye irritation, pain Yes No
loss of vision Yes No
Spots in vision Yes No
Other: _____

Respiratory

- Shortness of breath Yes No
Need for home oxygen Yes No
Chest pain Yes No
Cough Yes No
Chronic/Frequent cough Yes No
Difficulty breathing at rest Yes No
Difficulty breath on exertion Yes 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
- Entire health records, (including, but not limited to information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities).
- Other
- Discharge summary
- Laboratory reports
- Photographs/videotapes
- Records from other facilities

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.