ORLANDO UROLOGY ASSOCIATES, P.A.

New Patient Information

Personal Information

Full Name		SSN	Date of Birth
Have you been seen here before? ☐yes ☐no	Referring Doctor	Is this a work related injury or illness? ☐yes ☐no	

Contact Information

Street Address	Apt#	City	ZIP
Home Phone	Cell Phone	Email	

Emergency Contact Information

Name	Relationship	Phone
May we discuss your medical care and financial account with this person? ☐yes ☐no		

Insurance Information

Please provide your cards to the receptionist for copies

Primary Insurance	Are you the primary insured on this plan? ☐yes ☐no	
If **not** please provide the following:		
Primary Insured Name:	Date of birth	Telephone #
Place of employment	Relationship	

Secondary Insurance	Are you the primary insured on this plan? ☐yes ☐no	
If **not** please provide the following:		
Primary Insured Name:	Date of birth	Telephone #
Place of employment	Relationship	

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Payment/Financial Policy

It is the policy of this practice that the patients are ultimately responsible for the payment for medical services to the extent allowed by law or regulation. Please remember the insurance company works for you-you pay your premiums to them and they have no obligation to us except through you as our patient.

- HMO Patients: You must have a referral for our office to be paid by your insurance. If unable to obtain a referral please reschedule your appointment and contact your Primary Care Doctor.
- Required Co-payments: Please pay at the time of service. You may receive an additional bill for any applied deductibles as dictated by your specific plan benefits.
- Payment Options: Please see one of our billing specialists to make payment arrangements. We accept Visa and Mastercard.
- Returned Checks: An additional charge of $15.00 will be added for any returned checks.
- Credit Bureau: We will notify you in the form of monthly statements of any outstanding bills. Failure to satisfy the debt will result in your account being reported to the three major credit agencies. Please contact our billing department for payment arrangements.

Assignment of Claims: *I hereby instruct my insurance company to make payments directly to Orlando Urology Associates for any claim resulting from medical care provided to me. I have read The Payment Policy and my questions have been answered. I agree that a reproduction of this statement and my signature are valid as the original.*

Signature of Patient or Guarantor, if other than patient	Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Pledge Regarding Medical Information

We understand that information about you and your health is personal. We are committed to protecting that medical information. This notice applies to all of the records of your care generated by Orlando Urology Associates, whether made by your personal physician or our employees.

We are required by law to: make sure your health-related information that identifies you is kept private; give you this notice of our legal duties and privacy practices; and follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information About You

- For Treatment
- For Payments
- Appointment Reminders
- Individuals Involved in Your Care or Payments of Your Care
- As Required by Law
- To Prevent a Serious Threat to Health or Safety

Your Rights Regarding Medical Information About You

You have the following rights regarding the medical information we obtain about you:

- Right to inspect and copy (fee may apply)
- Right to Amend – must be in writing with supporting information
- Right to an Accounting of Disclosures with exception of the following: disclosures you authorize; disclosures to carry out treatment, payment and healthcare operations; and disclosures to persons involved in your healthcare.
- Right to Request Restrictions
- Right to Request Confidential Communications We reserve the right to make changes to this notice at any time.

Thank You for allowing us to participate in your medical care.

Signature	Date

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Review of Symptoms

Do you now or have had problems related to the following systems?
Mark the appropriate box below. Please explain and **YES** answers in the space provided.

Constitional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Other _____		

Eyes

Blurred Vision	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Other _____		

Allergic/Immunologic

Hay Fever	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Other _____		

Neurological

Tremors	☐ Yes	☐ No
Dizzy spells	☐ Yes	☐ No
Numbness/Tingling	☐ Yes	☐ No
Other _____		

Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot/cold	☐ Yes	☐ No
Tired/Sluggish	☐ Yes	☐ No
Other _____		

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No
Other _____		

Cardiovascular

Chest pain	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Other _____		

Integumentary

Skin rash	☐ Yes	☐ No
Boils	☐ Yes	☐ No
Persistent itch	☐ Yes	☐ No
Other _____		

Musculoskeletal

Joint pain	☐ Yes	☐ No
Neck pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No
Other _____		

Respiratory

Wheezing	☐ Yes	☐ No
Frequent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Other _____		

Hematologic/Lymphatic

Swollen glands	☐ Yes	☐ No
Blood clotting problem	☐ Yes	☐ No
Other _____		

Physician use only: (Comments/Notes)	
Physician	Date

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History of Present Illness

What is the main reason for your visit today?		
When did you first notice the problem?	How long does the problem last?	Do any factors make problem worse?
Is the problem constant or variable?		Pain Scale ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Past Medical and Social History

Do you now or have you ever had any of the following:

Cancer of the:

Kidney	☐yes	☐no
Bladder	☐yes	☐no
Prostate	☐yes	☐no
Testicular	☐yes	☐no

Other _____

Frequency of urination problem	☐yes	☐no	Incontinence (leakage of stool)	☐yes	☐no
Pain or Burning while urinating	☐yes	☐no	Decreased flow of urination	☐yes	☐no
Strong urgency to urinate	☐yes	☐no	Blood in urine	☐yes	☐no
Frequent Urination at night	☐yes	☐no	Difficulty in starting to urinate	☐yes	☐no
Incontinence (leakage of urine)	☐yes	☐no	Recurrent urinary infections	☐yes	☐no

Do you Smoke?	☐yes	☐no	Do you drink alcohol?	☐yes	☐no
For how long?	_____		How much per day?	_____	
How much per day?	_____		Any other drug use?	_____	

Previous Surgeries/hospitalizations	
Current Medications: (including regular use of Aspirin):	
Pharmacy	Pharmacy Telephone#
Allergies ☐yes ☐no *If "yes" please list below*	