UROLOGY CENTER OF PALM BEACH, P.A.

Name _____ Date _____

Date of Birth _____ Age_____ Sex (circle one) M F

Social Security #_____

Marital Status (circle one) Married Divorced Single Widowed Separated

Home Address _____ City_____ Zip_____

Home Phone _____ Work Phone _____

Cell Phone _____ Race _____ Language_____

Emergency Contact (NOT living with you)

Name _____ Relationship _____

Home Phone # _____ Work/Cell Phone _____

I heard about this practice from (check)

( ) Physician ( ) Newspaper ( ) Friends and/or family
( ) Yellow Pages ( ) Palm Beach Post ( ) Other

Referring Physician _____ Specialty _____

Phone # _____

Primary care Physician (if different from above)

_____ Phone # _____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT FORM

I have been provided the opportunity to review Dr. Diego Rubinowicz's Notice of Privacy Practices.

Name _____ Date _____

Signature _____

I have been provided an opportunity to review the Privacy Notice and **DO NOT** wish to sign the acknowledgment form.

SIGNATURE_____ DATE _____

INSURANCE INFORMATION

Primary Insurance: _____
Secondary Insurance: _____

I hereby authorize and assign payment to Urology Center of Palm Beach, P.A. for all insurance medical benefits. I also understand my responsibilities of payment for any and all charges not payable under this assignment. Payment, including copays, is also expected in full at the time services are rendered.

Urology Center of Palm Beach does NOT file claims with secondary insurances with the following exceptions: Medicare is the primary insurance and there is a supplemental insurance, Medicare/Medicaid is the secondary insurance. However, we will supply all the paperwork needed for the patient to submit the claim to his/her secondary insurance.

I understand and agree that, regardless of my insurance status, I am fully responsible for the balance of my account and for a 30% fee incurred for the collect of debt.

PHARMACY INFORMATION

Name: _____ Phone number:_____

Address: _____

NO SHOW POLICY

I _____ understand that there will be a $30.00 no show fee that I am fully responsible for if I do not call and cancel my appointment at least 24 hours in advance.

I understand that there will be a $50.00 no show fee for any in-office missed/cancelled procedures without a 48-hour notice.

I understand that there will be a $100 no show fee for any out-of-the-office missed/cancelled procedures without a 5 business day notice.

MALPRACTICE INSURANCE

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims in medical malpractice. This notice is provided pursuant to Florida law.

The undersigned patient acknowledges the receipt of the insurance information, no-show and malpractice insurance notices.

Patient's Signature Printed Name Date

UROLOGY CENTER OF PALM BEACH, P.A.

Age: _____ Date: ___/___/___ Name: _____

Reason for Visit:

_____

Medical History (check if applicable)

[ ] High blood pressure	**[ ] Asthma/lung problems**	**[ ] Urinary problems**
[ ] Heart disease	**[ ] Ulcers**	**[ ] Kidney problems**
[ ] Stroke	**[ ] Liver disease**	**[ ] Prostate problems**
[ ] Diabetes	**[ ] Cancer/Tumors**	**[ ] sexually transmitted dis**

Other:

_____

Surgeries: (list all)

1) _____ 2)_____3)_____

4)_____ 5)_____ 6)_____

Family History: (check all applicable)

[ ] Kidney Stones **[ ] Bladder Cancer**
[ ] Other kidney disorders **[ ] Prostate cancer (male patients only)**
[ ] Other:_____

Medications:

1) _____ 2)_____ 3) _____

4) _____ 5) _____ 6) _____

_____

Do you take any blood thinners such as aspirin, coumadin or plavix? Yes No

Allergies:

_____

Do you have any of the following? Circle Yes or No

Fever	**Yes**	**No**	**Shortness of breath**	**Yes**	**No**
Chills	**Yes**	**No**	**Coughing**	**Yes**	**No**
Nausea	**Yes**	**No**	**Wheezing**	**Yes**	**No**
Vomiting	**Yes**	**No**			
Headache	**Yes**	**No**	**Bleeding problems**	**Yes**	**No**
Blurred Vision	**Yes**	**No**	**Swollen glands**	**Yes**	**No**
Double Vision	**Yes**	**No**			
			Bone Pain	**Yes**	**No**
Hay Fever	**Yes**	**No**	**Back Pain**	**Yes**	**No**
			Flank Pain	**Yes**	**No**
Tremors	**Yes**	**No**			
Dizziness	**Yes**	**No**	**Blood in Urine**	**Yes**	**No**
Numbness/Tingling	**Yes**	**No**	**Slow Stream**	**Yes**	**No**
			Frequency	**Yes**	**No**
Abdominal Pain	**Yes**	**No**	**Urge to urinate**	**Yes**	**No**
Heartburn	**Yes**	**No**	**Unable to urinate**	**Yes**	**No**
Diarrhea	**Yes**	**No**	**Incontinence**	**Yes**	**No**
			Sexual Problems	**Yes**	**No**
Chest Pain	**Yes**	**No**			
Palpitations	**Yes**	**No**			
Irregular Heartbeat	**Yes**	**No**			

Smoking:

_____ packs per day for _____ years
[ ] Cigars
[ ] Quit _____ years ago
[ ] Never smoked

Alcohol:

_____drinks/beers per day for _____ years
[ ] Occasionally
[ ] Never

Recreational Drugs:

_____

Have you ever had diseased heart valves, hip replacement or other prosthetic implants? Yes No

IPSS SYMPTOM SCORE (for male patients ONLY)

PATIENT NAME: _____ TODAY'S DATE: _____

Circle one number on each line **Over the past month**	**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**
Incomplete emptying - How often have you had the sensation of not emptying your bladder completely after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
Frequency - How often have you had to urinate again less than two hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
Intermittency - How often have you found you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**
Urgency - How often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**
Weak stream - How often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
Straining - How often have you had to push or strain to begin urination?	**0**	**1**	**2**	**3**	**4**	**5**
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**
Sleeping - How many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	**0**	**1**	**2**	**3**	**4**	**5**

Add the score for each number above and write the total in the space to the right. TOTAL: _____

SYMPTON SCORE: 1-7 (MILD) 8-19 (MODERATE) 20-35 (SEVERE)

QUALITY OF LIFE (QOL)

	Delighted	**Pleased**	**Mostly Satisfied**	**Mixed**	**Mostly Dissatisfied**	**Unhappy**	**Terrible**
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Have you tried medications to help your symptoms? (circle) YES NO

Did these medications help your symptoms? (circle)

1 2 3 4 5 6 7 8 9 10

No relief Completely cured

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications? (circle) YES NO

ADAM questionnaire about symptoms of low testosterone (Androgen Deficiency in the Aging Male) TO BE COMPLETED BY MALE PATIENTS ONLY

This basic questionnaire can be very useful for men to describe the kind and severity of their low testosterone symptoms.

	Yes	No
1. Do you have a decrease in libido (sex drive)?		
2. Do you have a lack of energy?		
3. Do you have a decrease in strength and/or endurance?		
4. Have you lost height?		
5. Have you noticed a decreased "enjoyment of life"?		
6. Are you sad and/or grumpy?		
7. Are your erections less strong?		
8. Have you noticed a recent deterioration in your ability to play sports?		
9. Are you falling asleep after dinner?		
10. Has there been a recent deterioration in your work performance?		

If you Answer Yes to number 1 or 7 or if you answer Yes to more than 3 questions, you may have Low Testosterone.