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

AUA SYMPTOM SCORE

PATIENT NAME: ________________________________ TODAY'S DATE: ____________

Circle one number on each line	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
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
During the past month or so, how often have you found you stopped and started again several times when you urinated?	**0**	**1**	**2**	**3**	**4**	**5**
During the past month or so, how often have you found it difficult to postpone urination?	**0**	**1**	**2**	**3**	**4**	**5**
During the past month or so, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
During the past month or so, 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**
Over the past month, 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**

ADAM questionnaire about symptoms of low testosterone (Androgen Deficiency in the Aging Male)

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.