Patient Registration Form

Date:____________________

Patient Name: ____________________ Date of Birth: ________________

Social Security: ____________________

Address: ____________________ Apt#:________________

City: ________State:______Zip:________Phone:________________

Cell Phone: ________________Emergency:________________

Email Address:______________________________

( ) Male ( ) Female ( ) Married ( ) Single ( ) Widowed ( ) Divorced

---

Skilled Nursing Home or Assistant Nursing Home Living

Address: ______________________________

City: ________State: ______Zip: ______Phone:________________

Insurance: ________________ Member ID#:________________

Primary Care Physician: ________________Phone#:________________
(Full Name)

Responsible Party: ________________ Relationship:________________

Address: ________________ City: ________________

State: ______ Zip: ______ Phone: ________________

Employer: ________________Occupation:________________

Address: ________________Phone:________________

Workers Comp Carrier: ______________________________

Claim #: ________________Date of Accident: ________________

Adjuster: ________________ Case Manager:________________

____

PATIENT SIGNATURE DATE

Rev. 7/10/2010 jaf

UROMEDIX
PROVIDING UROLOGIC CARE & SURGERY
A Division of 21st Century Oncology, LLC

Medications and Allergies List

Today's Date ____________________

Patient Name ______________________________________ Acct. # ________

What Medicines are you presently using? (Include Non-Prescription Drugs, Nutritional Supplements, and Herbal Remedies) Please notify us of any changes on follow-up visits so that we can update your list.

Date	Medication/Vitamins	Dosage	How Many Times a Day

Do you have a heart valve disease that requires antibiotics before a procedure? ________
Have you had any other procedures that require antibiotics? ________
Are you Allergic to any medicines? ☐ **NO KNOWN DRUG ALLERGIES**

Medicine	Reaction or Side Effect	Medicine	Reaction or Side Effect
☐ Penicillin		☐ Iodine	
☐ Sulfa		☐ Other	
☐ Other		☐ Other	

URO MEDIX

PROVIDING UROLOGIC CARE & SURGERY
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New Patient History Form

Patient ID #: ______________

Name ______________________, ______________________ **Date** ____/____/______
(Last) (First)

Date of Birth ____/____/_____ **Age** _______ **Email Address:** ______________________

Referring Physician's Name: ____________ **Primary Care Physician:** ______________

Main Reason for today's visit: ____

____

Please give detailed information about the ***Present Problem*** (e.g. When did it start? How long does it last? Does anything make it better or worse? Severity? Is it constant or variable? Location? Etc.):

____

____

____

Any ***Other Urologic Problems***: (Please check those that apply):

☐ Urinary Frequency (How many hours can you go without urinating? __________ hours),

☐ Urgency to urinate (How many times do you urinate in 24 hours? __________/ day)

☐ Nocturia (About how many times do you have to get out of bed to urinate while sleeping?) ___________

☐ Incontinence (Do you use pads or change underwear?) ________ How many? ________/ day

☐ Decreased Stream ☐ Retention or Sensation of Incomplete Emptying

☐ Post Void Dribbling ☐ Hesitancy ☐ Dropped Bladder

☐ Urinary Burning/Pain ☐ Frequent Urinary Infections ☐ Blood in Urine

☐ Sexual Problems/Impotence ☐ Sexually Transmitted Disease ☐ Bladder

☐ Kidney Stones ☐ Prostate Problems ☐ Other

Personal Medical History:

☐ Heart Disease ☐ High Blood Pressure ☐ Heart Valve Disease

☐ Diabetes ☐ Hepatitis ☐ Gout

☐ Bleeding Problems ☐ Stroke ☐ Irritable Bowel

☐ Asthma/Emphysema ☐ T.B. ☐ Thyroid Disease

☐ HIV ☐ Cancer ☐ Other

Surgical History and/or Hospitalizations: (Please list approximate date)

Surgery	Month/Year	Surgery
☐ Hernia	______________	______________
☐ Vasectomy	______________	______________
☐ Appendectomy	______________	______________
☐ Other	______________	______________

Last **PSA** (Prostate Cancer Screening Blood Test) Test Result: _____________ Date: _____________

DO NOT WRITE BELOW THIS LINE

____

CONTINUED ON BACK

Social History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Do you now or have you ever smoked? ☐ Yes ☐ No If Yes, when did you quit? Date: ____________

How many packs per day? ______________ Smoking for how many years? __________

How much Beer, Wine, or Alcohol do you drink per week? __________ Recreational drugs? ☐ Yes ☐ No

What kind of work do you do know or did you do? ______________________________

Exposure to chemicals, toxins, fumes, radiation or excessive heat (regular use of Hot Tub, Jacuzzi, Sauna or Whirlpool)? ______________________________

How much Coffee, Tea, Iced Tea, or Caffeinated Beverages? _______ How much water do you drink? ________

Do you eat a lot of spicy, pickled or acidic foods? ☐ Yes ☐ No

Family History:

List serious illnesses that may run in your family (e.g. Porstate Cancer, Kidney Stones, Kidney Disease, Diabetes, Cancer, Cystic Fibrosis, Etc.).

Mother ____________________ Brother/Sister ____________________ Other ____________________

Father ____________________ Brother/Sister ____________________ Other ____________________

Review Of Systems

(Please check Yes or No to All Questions Below)

Constitutional Symptoms

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No

Eyes

Blurred Vision	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No

Allergic / Immunologic

Hay Fever	☐ Yes	☐ No
Multiple Allergies	☐ Yes	☐ No

Neurological

Tremors	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No
Numbness / Tingling	☐ Yes	☐ No
Weakness	☐ Yes	☐ No

Endocrine

Excessive Thirst	☐ Yes	☐ No
Intolerant to Heat/Cold	☐ Yes	☐ No
Excessive Fatigue	☐ Yes	☐ No

Gastrointestinal

Abdominal Pain	☐ Yes	☐ No
Constipation/Diarrhea	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Indigestion/Heartburn	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No

Cardiovascular

Chest Pain	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
Poor Circulation	☐ Yes	☐ No
Ankle Swelling	☐ Yes	☐ No

Skin

Skin Rash	☐ Yes	☐ No
Boils	☐ Yes	☐ No
Persistent Itch	☐ Yes	☐ No

Musculoskeletal

Joint Pain	☐ Yes	☐ No
Neck Pain	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No

Ear/Nose/Throat/Mouth

Ear Infection	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No

Gynecological (Females Only)

No. Of Pregnancies __________

No. of Live Births __________

C-Section	☐ Yes	☐ No
Hysterectomy	☐ Yes	☐ No

(If yes, please check one that applies)

☐ Abdominal ☐ Vaginal ☐ Total

☐ Partial ☐ Ovaries Removed ☐ Other

Respiratory

Wheezing	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No

Hematologic/Lymphatic

Swollen Glands	☐ Yes	☐ No
Blood Clotting Problem	☐ Yes	☐ No
Mumps	☐ Yes	☐ No

Psycologic

Do you feel severely depressed?	☐ Yes	☐ No
Anxiety/Excessive nervousness?	☐ Yes	☐ No

Other

OFFICE USE ONLY

Height: ____________ **Weight:** ______________ **BP** **P** **R**

DO NOT WRITE BELOW THIS LINE

Patient Name: ______________________
Date of Birth: ______________________
Medical Record Number: ______________________
Patient Phone Number: ______________________

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I authorize the use or disclosure of the above named individual's health information

2. The following individual or organization is authorized to make the disclosure:

   Name: ______________________

   Address: ______________________

3. The type and amount of information to be used or disclosed is as follows:

   _________ Physician Dictation
   _________ Dosimetry Records
   _________ Radiology Reports
   _________ Diagnostic Films
   _________ Laboratory Results
   _________ Consultation Reports
   _________ Surgery/Pathology
   _________ Portal Films/Simulation Films
   _________ Other: ______________________

   The time frame for the disclosure information is: from (date) ___________ through (date)__________

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

   Name: ______________________

   Address: ______________________

   ____

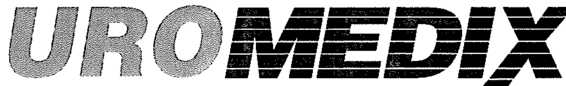
   Purpose of ______________________

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date of signature.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided by CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Director.

______________	______________________	______________
Date	Patient Signature or Legal Representative	Witness

If signed by legal representative, state the relationship to the patient: ______________________



PROVIDING UROLOGIC CARE & SURGERY
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NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this health information. Please read it carefully and ask any questions.

WHAT IS HEALTH INFORMATION:

Each time that a service is rendered or a procedure is done, even as simple as a routine blood pressure check, data and information are collected. This is health information or what is commonly referred to as information for or in the medical record or the patient record. Accurate, credible, and timely data and information are used by this facility as the basis for planning your care, as a means of having multiple healthcare providers know about your current health status, as a health legal document, as a record for billing purposes, as a source of data for research, planning, and marketing, as a source of required information for public health officials, and as a means to continue to improve the care that we provide. At this facility, we have always, and will continue to protect the privacy of your health information and the dignity of you as an individual. On July 6, 2007, the .S. Federal Government passed compliance regulations that mandate all healthcare facilities to protect health information and inform consumers of the healthcare information practices of the facility.

THE CONSUMER'S HEALTH INFORMATION RIGHTS:

This facility maintains a medical record for you containing medical information concerning you. With this in mind, you have the right to:

- Request a restriction on use and disclosure of health information, although the facility is not required to comply (45 CFR 164.522)
- Obtain a copy of this notice
- Inspect and receive a copy of your medical record (45 CFR 164.524)
- Amend your medical record (45 CFR 164.528)
- Obtain an accounting of disclosures of your medical record (45 CFR 164.528)
- Request your medical record by alternative means or location
- Revoke your authorization to use or disclose your health information except to the extent that action has already been taken.

THE FACILITY'S RESPONSIBILITIES

This facility's mission of quality service and respect of the individual has always taken into account protecting health information privacy.
Our responsibilities are to:

- Maintain the privacy of your health information
- Provide you this notice of health information practices
- Notify you if we are unable to satisfy a request
- Accommodate all reasonable requests while maintaining quality care and respect for you
- Make you aware of all health information practice policy changes
- We will not use or disclose your health information without your approval except as stated in this notice

TO REQUEST FURTHER INFORMATION OR ASK QUESTIONS:

If you would like further information or have questions, this facility, Uromedix employs a Compliance Officer who can be reached at 305-466-9111.
If you believe that your privacy rights have been violated, you can file a complaint with the Compliance Officer or with the Secretary of Health and Human Services. There will be no penalty or retaliation for filing a complaint.

Examples of Permitted Types of Uses and Disclosures of Health Information:

This facility may use or be required to use your health information without your authorization or consent for normal business activities as follows:

For Care and Treatment: Health information obtained by a healthcare practitioner such as a physician, nurse, or therapist, will be entered into your medical record and used to determine a plan of care. For example, healthcare members will write and read what others have written such as that your care can be coordinated and everyone is aware of how you are responding to your treatment plan. When you are discharged from this facility, your health information may go with you such that future healthcare providers will have a record of your care. Your health insurer may disclose health information to the sponsor of the plan. Information regarding your care will be provided to your referring physician and/or your primary care physician for coordination of care.

For Billing and Payments: Health information on a bill sent to an insurer may include health information. This health information is restricted to that which is needed for the financial transactions. At times, the insurance company may require records sent with the bill for payment.

For Health Operations: I order to provide quality care, healthcare providers at this facility may use your health information, for example, to analyze the care, treatment, and outcomes of your medical case and of others. This health information will be used to continually improve the care of the services that we provide to you.

For Business Associates: In order to provide quality care, this facility requires business services such as pharmacy, medical equipment, medical laboratories, etc. These services will have use of your health information as it pertains to their service delivery. Also, please know that these businesses must follow our standards for protecting your health information.

For Notification: We may use or disclose health information, such as your general condition, to notify or assist in notifying a family member or other person responsible for your care.

For Communication: We may use or disclose health information to family members or those that you deem responsible for your care, health information relevant to your care and their need to know.

For Research: Uromedix has a business relationship with South Florida Medical Research Corp. (SFMR) and may disclose health information to them for research purposes only unless notified by you in writing. SFMR will adhere to this facility's health information privacy standards.

For Funeral Directors: We may disclose health information to funeral directors in accordance with state laws and for professional purposes only.

For Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or organizations involved in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

For Marketing Purposes: We may contact you to provide information on appointment reminders or alternative treatments and services that may benefit you given your medical condition.

For the Food and Drug Administration: As requested or required by the FDA, we may disclose health information relative to an adverse health condition related to food, food supplements, product and product defects related to food, or post marketing surveillance information to allow product recalls, repairs, or replacements.

For Workers Compensation Issues: In compliance with the Worker's Compensation laws, health information may be revealed to the extent necessary to comply with the law and your individual case.

For Public Health Requirements: As required by law, health information may be disclosed to public health or legal authorities for the jurisdiction of disease, injury, or disability prevention or control.

For Correctional Institutions: Should you be an inmate in a correctional institution, health information may be disclosed to the institution or its agents that which would be necessary for your health and safety and the health and safety of other individuals.

For Law Enforcement Agencies: Health information may be disclosed to law enforcement agencies for purposes required by law or subpoena.

For Health Care Oversight: Patient health information may be used by health oversight agencies for activities such a audits, inspections, and licensure activities.

For Specialized Government Functions: In the event that appropriate military authorities require information, it may be released at the minimum necessary level.

For Victim of Abuse, Neglect, and Domestic Violence: Information may be released to social service agencies or protective services in order to protect an individual.

Other uses and disclosures are to be made with your written authorization and you may revoke such authorization at any time.

Effective Date: 10/27/2008

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES

I, ____, have received a copy of Uromedix Notice of Health Information Practices.

____

PRINT NAME

____

SIGNATURE

____

DATE

____

FOR STAFF USE ONLY

____

We attempted to obtain written acknowledgement of receipt of our Notice of Health Information Practices, but acknowledgement could not be obtained because:

- ¤ Individual refuses to sign
- ¤ Communication barriers prohibited obtaining acknowledgement
- ¤ An emergency situation prevented us from acknowledgement
- ¤ Other (Please Specify)

____

____

____

____

PATIENT NAME

____

SIGNATURE OF STAFF MEMBER DATE

Rev. 7/10/2010 jaf