Advanced Urology

Eric R. Freedman, M.D., Inc.
PHONE: (209) 532-5244 FAX (2090 532-5247

DATE_____

PATIENT NAME_____BIRTHDAY_____

MAILING ADDRESS_____CITY_____ZIP_____

HOME PHONE_____WORK PHONE_____SS#_____

AGE____MALE____FEMALE____MARITAL STATUS: **S M D W**

SPOUSE'S NAME_____

YOUR EMPLOYER/OCCUPATION_____

EMERGENCY CONTACT_____RELATIONSHIP_____PHONE_____

PRIMARY PHYSICIAN_____REFERRED BY_____

PREFERRED PHARMACY_____

Are you allergic to any medications? Yes No If yes, please list:_____

IN ORDER TO BILL YOUR INSURANCE, WE MUST HAVE AN ADDRESS FOR CLAIMS; THIS INCLUDES YOUR SECONDARY INSURANCE. IF YOU HAVE YOUR INSURANCE CARDS WITH YOU, PLEASE ALLOW US TO COPY THEM AND YOU NEED ONLY TO SIGN, PRINT YOUR NAME AND DATE BELOW. THANK YOU.

PRIMARY INSURANCE_____

SUBSCRIBER NAME_____

GROUP #_____ID#_____

MAILING ADDRESS FOR CLAIMS_____

CLAIMS TELEPHONE #_____

MEDICARE #_____

SECONDARY INSURANCE_____

SUBSCRIBER NAME_____SUBSCRIBER'S BIRTHDATE_____

GROUP#_____ID#_____

MAILING ADDRESS FOR CLAIMS_____

CLAIMS TELEPHONE #_____

RELEASE OF INFORMATION AND AUTHORIZATION FOR INSURANCE PAYMENT TO ERIC FREEDMAN, M.D.

I UNDERSTAND THAT MY SIGNATURE BELOW AUTHORIZES MY INSURANCE CARRIER TO MAKE PAYMENT FOR SERVICES RENDERED TO: ERIC FREEDMAN, M.D. AND THAT IN ORDER FOR THE INSURANCE CARRIER TO PAY BENEFITS, ERIC FREEDMAN, M.D. WILL BE RELEASING INFORMATION TO MY INSURANCE CARRIER REGARDING MY MEDICAL CONDITION.

SIGNED_____PRINT NAME_____DATE_____

Advanced Urology – Eric Freedman, M.D.

PATIENT HISTORY FORM

Note: this is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE ___/___/_____ DATE OF LAST PHYSICAL EXAM ___/____/____.

LAST NAME _____FIRST NAME _____NICK NAME_____

SOCIAL SECURITY NO. _____ DATE OF BIRTH ___/____/_____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

_____

HISTORY OF PRESENT ILLNESS

Please answer the following questions

Location of the problem? (please circle)
Abdomen Back Leg
Other:_____

On a scale of 1-10, with 10 being the most severe,
Circle the number that best describes the problem?
1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other _____

Does anything help or make the problem worse?
Moving around Standing up Lying on my side

Other

_____

How long does the problem last? (please circle)
30 minutes 1 hour It is always there
Other _____

Is anything else occurring at the same time?
Yes or No If yes, please explain
Nausea Rash Headaches
Other _____

Is the problem constant or variable?
Dull then Sharp Very Sharp then leaves Always there
Other _____

Does the problem interfere with your normal functions?
Yes or No If yes, please explain

_____

PAST MEDICAL, FAMILY & SOCIAL HISTORY

Please list ALLERGIES:_____
Please list MEDICATIONS:_____

_____

MEDICAL ILLNESSES: (circle all that apply) Diabetes Heart Problems Thyroid Problems
High Blood Pressure Arthritis High Cholesterol Asthma Prostate Other_____

PAST SURGERIES: (circle all that apply) Hernia Heart Bypass or Valve Bowel Appendix
Prostate Vasectomy C-Section Bladder Lift Hysterectomy Other:_____

FAMILY HISTORY: (Circle all that apply) Diabetes Heart Disease High Blood Pressure
Prostate Cancer Breast Cancer Kidney Disease Kidney Stones Other:_____

SOCIAL HISTORY:

Do you Smoke? Yes or No How Much?_____ Do you Drink Alcohol? Yes or No How Much?_____

Do you drink Coffee? Yes or No How Much?_____ Are you on any Special Diet? Yes or No _____

Martial Status Married Widowed Divorced Single --- Occupation?_____

Have you ever had a blood transfusion? Yes or No

Patient Name: _____

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No.**

Constitutional Symptoms
Fever Y N
Chills Y N
Headache Y N
Other _____

Eyes
Blurred vision Y N
Double vision Y N
Pain Y N
Other _____

Allergic/Immunologic
Hay Fever Y N
Drug Allergies Y N
Other _____

Neurological Y N
Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Other _____

Endocrine
Excessive thirst Y N
Too Hot/Cold Y N
Tired/Sluggish Y N
Other _____

Gastrointestinal
Abdominal Pain Y N
Nausea/vomiting Y N
Indigestion/Heartburn Y N
High Blood Pressure Y N
Other _____

Cardiovascular
Chest Pain Y N
Varicose Veins Y N
High Blood Pressure Y N
Other _____

Integumentary
Skin Rash Y N
Boils Y N
Persistent Itch Y N
Other _____

Musculoskeletal
Joint Pain Y N
Neck Pain Y N
Back Pain Y N
Other _____

Ear/Nose/Throat/Mouth
Ear Infection Y N
Sore Throat Y N
Sinus Problem Y N
Other _____

Genitourinary
Urine Retention Y N
Painful Urination Y N
Urinary Frequency Y N
Other _____

Respiratory
Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other _____

Hematologic/Lymphatic
Swollen Glands Y N
Blood Clotting Problem Y N
Other _____

Psychologic
Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N

Other _____

Is there anything else we should know about your medical History or present symptoms?

_____

_____

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NO-SHOW OFFICE POLICY

DATE_____

Please be aware of a $25.00 fee for NOT showing up for your appointment. We realize emergency situations arise – we also realize sometimes our patients start feeling better and our services are not needed. This office requires a 48-hour cancellation notice – a $25 charge will be added to your bill (NOTE: this fee is not paid by or billed to insurance companies). If an emergency arises and you are not able to make your appointment it is necessary to contact the office immediately or this charge will be applied. If you have three [3] no-show occurrences – you will be asked to find another physician for your Urological care.

In order to remind you of your appointment, please provide the following information:

Primary Phone:_____

Secondary Phone:_____

Cell Phone:_____

Relative Phone:_____

E-mail address:_____

I UNDERSTAND THAT MY SIGNATURE BELOW CREATES AN UNDERSTANDING OF OUR NO-SHOW APPOINTMENT POLICY AND FEES ASSOCIATED WITH THIS POLICY.

SIGNED_____PRINT NAME_____

ACKNOWLEDGMENT OF RECEIPT OF

Advanced Urology

OUR NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of the *Advanced Urology* Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by *Advanced Urology* and how I may obtain access to and control this information.

X_____.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

X_____.

DATE:_____

DESCRIPTION OF PERSONAL REPRESENTATIVES AUTHORITY

1. Please list who you want to have access to your pertinent medical information?

   (i.e.: family member, spouse, significant other)

2. May we leave message on answering machine? YES NO

3. Preferred method of contact?

Home #_____Cell #_____Work #_____.

THIS SECTION WILL BE COMPLETED IF THE WRITTEN ACKNOWLEDGEMENT NOT OBTAINED

We have made a good faith effort to obtain an individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s):

___The individual refuses to sign or otherwise fails to provide an acknowledgement

___The individual was mailed a copy of the Notice and did not mail back his or her receipt of acknowledgement.

Other_____

Completed by_____Date:_____

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PATIENT CONSENT

We are committed to treating your healthcare and personal information with the utmost privacy and security.

It is necessary to provide your medical information to your insurance carrier(s) at the time of billing for services provided to you.

We will be providing your insurance, demographic and health information to providers outside our office in the following situations:

1. When specimens are sent from our office.
2. When scheduling services for you in X-ray or surgery.
3. When referring you to another physician.

Your signature below indicates that you understand that it is necessary to provide your personal and healthcare information in the above circumstances, and that you are giving us permission to use your personal and healthcare information in the above circumstances only.

Please Note: Dr. Freedman frequently send your urine samples to an outside laboratory for testing. If for any reason, you have a preference for treatment of these tests, please notify the nurse at the time of your visit.

Signed:_____Date:_____

Printed Name:_____

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Request to Inspect Protected Health Information:

You may generally inspect or request copies of your protected health information that we maintain. As permitted by Federal regulation, we require the requests to inspect received copies of the information be submitted in writing. You may obtain a request from the office staff. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Federal regulations require compliance with a patient request to inspect or copy patient records within 60 days of the request. It also stipulates a fee may be charged to the patient for this service.

The privacy rules give patient the right to request amendments or changes to their medical records. Medical practices aren't obligated to make any changes. Any objection or correction you feel needs to be made to your medical records must be put in writing and this will be come a permanent part of your medical records. No report dictated by the doctor will be changed, however your statement concerning that report will become part of your record.

Complaints: If you would like to submit a comment or complaint about our privacy practices, or receive further information concerning our privacy practices, please write to:

Office Manager
Eric R. Freedman MD, INC.
680 Guzzi Lane, Suite 203
Sonora, CA 95370

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

PATIENT SIGNATURE

By signing below, I verify I have been given a Privacy Policy by a member of Eric R. Freedman MD, INC.'s office staff. This only verifies I have been given the document, not necessarily that I agree with it.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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RELEASE OF MEDICAL INFORMATION

FOR PATIENT: _____

TO PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

FAX: _____

PLEASE SEND ALL LABORATORY, PATHOLOGY, RADIOLOGY, OPERATIVE NOTES AND CONSULTS FOR:

PATIENT: _____

_____

AS REQUESTED BY: _____

SIGNED: _____ DATE: _____

PRINTED NAME OF PATIENT: _____

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Map to Office