ROSENBERG
UROLOGY & UROLOGICAL SURGERY

Patient Information

Name:	______________	D.O.B.:	______________
Address:	______________	City:	______________
State:	______________	Zip:	______________
Home Phone:	( ) -	Cell Phone:	( ) -
Social Security:	______________	Marital Status:	______________
Sex:	______________	Age:	______________
Employer:	______________	Work Phone:	( ) -
Emergency Contact:	______________	Phone:	( ) -

Insurance Information

Primary:	______________	Secondary:	______________
Address:	______________	Address:	______________
City/State/Zip:	______________	City/State/Zip:	______________
Policy#:	______________	Policy#:	______________
Group#:	______________	Group#:	______________

Guarantor's Information

Name:	______________	D.O.B.:	______________
Employer:	______________	Work Phone:	______________
Relationship to Patient:	______________	SSN#:	______________

For medical services rendered to my dependent(s), or myself I herby authorize the following:
A.) Release of any information to obtain medical examination, treatmentrand/or payment (assignment of benefits to be valid until revoked by me in writing).
B.) Direct payment of benefits to Jerry H. Rosenberg, M.D.
C.) Photocopies of this form to be valid as the original.

Signature:	______________	Date:	______________
REFFERRED BY:	______________	**PHYSICIAN:**	______________

RELEASE OF PERSONAL MEDICAL INFORMATION

I,____ consent to the above office releasing my medical information to the following individuals:

____ ____
Name Relationship to Patient

____ ____
Name Relationship to Patient

____ ____
Name Relationship to Patient

____ ____
Name Relationship to Patient

____ ______________________
Patient Signature Date

____
Patient's Date of Birth

Expires 1 year from date of signature

FOR OFFICE USE ONLY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who maybe involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received you Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change Notice of Privacy Practices from time to time and that I may contact this organizatton at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are required to agree to my requested restrictions, but ifyou do agree then you are bound to abide by such restrictions.

Patient Name: ____

Signature of Patient or Legally Responsible Party: ____

Relationship to Patient: ____

Date: __________________________________

Expires 1 year from date of signature

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Aclcnowledgement, but was unable to do so as documented below:

Date: ___________________

Initials: __________________

Reason: ____

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[YES] [NO] **HAVE YOU BEEN SEEN PREVIOUSLY IN THIS OFFICE? if yes, when?**______________

--------PLEASE ANSWER ALL QUESTION THAT YOU CAN

[YES] [NO] PAIN OR BURNING WITH URINATION

[YES] [NO] BLOOD IN URINE AT ANY TIME

[YES] [NO] SLOW URINARY STREAM

[YES] [NO] DIFFICULTY STARTING URINATION

[YES] [NO] INABILTY TO HOLD URINE (WET PANTS)

[YES] [NO] BEDWETTING

[YES] [NO] KIDNEY INFECTIONS

[YES] [NO] BLADDER INFECTIONS

[YES] [NO] KIDNEY STONE

[YES] [NO] TUBERCULOSIS

[YES] [NO] RECENT FEVER OR CHILLS

[YES] [NO] URINATING TOO FREQUENTLY (MORE THAN 6 TIMES A DAY)

[YES] [NO] AWAKENING AT NIGHT TO URINATE MORE TI{AN ONCE

[YES] [NO] HAVE YOU BEEN TO A UROLOGIST BEFORE?

[YES] [NO] HAVE YOU HAD KIDNEY OR BLADDER X-RAYS BEFORE?

NAME: __________________________ AGE: __________________________

REFERRED BY: __________________________ TODAY'S DATE: __________________________

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DO YOU TAKE ASPIRIN OR ANY ASPIRIN-CONTAINING DRUGS? **[YES] [NO]**

LIST ALL MEDICATIONS YOU HAVE TAKEN IN THE LAST TEN (10) DAYS:

LIST PREVIOUS OPERATIONS: ____________________

LIST PREVIOUS SERIOUS ILLNESSES OR INJURIES: ____________________

HAS ANYBODY IN YOUR FAMILY HAD ? (circle all that apply)

CANCER	TUBERCULOSIS	DIABETES
KIDNEY FAILURE	KIDNEY STONE	HIGH BLOOD PRESSURE

DO YOU SMOKE CIGARETTES? **[YES] [NO]** HOW MANY PACKS PER DAY?_______

DO YOU DRINK ALCOHOLIC BEVERAGES? **NEVER OCCASIONAL MODERATE HEAVY**

HAVE YOU HAD PROBLEMS WITH....? (CIRCLE IF YES)

EYES	STOMACHE ACHES	DIZZINESS
EARS	BOWELS	WEIGHT LOSS
NOSE	DIARRHEA	ARTHRITIS
MOUTH / THROAT	ARMS AND LEGS	CONSTIPATION
HEART	SKIN	DIFFICULTY WALKING
LUNGS	WEAKNESS	PAIN
HIGH BLOOD PRESSURE	DIABETES	BLEEDING

NAME:____