ATLANTIC COAST UROLOGY, PA
ADULT AND PEDIATRIC
UROLOGY AND GENITOURINARY SURGERY

PATIENT HISTORY

WELCOME TO OUR PRACTICE

As a new patient, please fill out the information found below to the best of your ability. A few minutes of your time carefully answering the following questions will help our urologist accurately access your problem, give better care and assist in proper insurance submission.

Patient#__________ Physician__________ Today's Date__________

Patient Name__________ Age_____ Date of Birth__________

Chief Complaint (reason for visit)__________

HISTORY OF PRESENT ILLNESS

Location__________
(Where is problem or pain?)

Quality__________
(Example abnormal color, sharp, dull or constant, etc.)

Severity__________
(How severe is problem or pain on a scale of 1-10, 10 being the most severe)

Duration__________
(When did problem or pain start?)

Timing__________
(Does problem or pain occur at a specific time?after activity,eating,etc.)

Context__________
(Where & what were you doing at onset of problem or pain?)

Associated Signs & Symptoms__________
(What other associated problems have you been having?)

Modifying Factors__________
(What makes problem or pain worse or better?)

PATIENT MEDICAL & SOCIAL HISTORY

PATIENT MEDICAL HISTORY: Have you ever had the following (circle "yes" or "no", leave blank if uncertain):

Measles	Yes No	Arthritis	Yes No	Mitral Valve Prolapse	Yes No	Blood or Plasma Transfusions	Yes No
Mumps	Yes No	Venereal Disease	Yes No	Hernia	Yes No		
ChickenPox	Yes No	Anemia	Yes No	Asthma	Yes No	High or Low Blood Pressure	Yes No
Whooping Cough	Yes No	Bladder Infection	Yes No	AIDS or HIV+	Yes No		
Scarlet Fever	Yes No	Epilepsy	Yes No	Stroke	Yes No	ANY OTHER DISEASES (please list)	
Diphtheria	Yes No	Hepatitis	Yes No	Ulcer	Yes No	__________	
Smallpox	Yes No	Tuberculosis	Yes No	Thyroid Disease	Yes No	__________	
Pneumonia	Yes No	Diabetes	Yes No	Kidney Disease	Yes No	__________	
Rheumatic fever	Yes No	Cancer	Yes No	DATE OF LAST CHEST X-RAY_____		DATE OF LAST MAMMOGRAM (female) __________	
Heart Disease	Yes No	Polio	Yes No				

Do you have any artificial joints, heart valves, heart pacemaker or defibrillator?__________

MEDICATIONS: *(Include prescription, nonprescription and dosages)* __________

ALLERGIES: *(Include allergies to medication, Iodine, X-ray contrast material, shellfish, etc.)*__________

PAST SURGERY: (Include date of surgery)____________________

____

____

PATIENT SOCIAL HISTORY:

Marital status: Single:_____ Married:_____ Separated:_____ Divorced:_____ Widowed:_____
Use of Alcohol: Never:_____ Rarely:_____ Moderate:_____ Daily:_____
Use of Tobacco: Never:_____ Previously, but quit_____ Current packs/day:_____
Use of Drugs Never:_____ Type/Frequency ____________________

What is your occupation? (If retired, what was it prior to retirement?)____________________

FAMILY MEDICAL HISTORY:

	AGE	DISEASE(s)	IF DECEASED CAUSE OF DEATH
Father			
Mother			
Siblings			
Spouse			
Children			

REVIEW OF SYSTEMS

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

Constitutional Symptoms
- Fever Yes No
- Chills Yes No
- Headache Yes No
- Other _____

Gastrointestinal
- Abdominal pain Yes No
- Nausea/vomiting Yes No
- Indigestion/heartburn Yes No
- Other_____

Genitourinary
- Urine retention Yes No
- Painful urination Yes No
- Urinary frequency Yes No
- Other_____

Eyes
- Blurred vision Yes No
- Double vision Yes No
- Pain Yes No
- Other _____

Cardiovascular
- Chest pain Yes No
- Varicose veins Yes No
- High blood pressure Yes No
- Other_____

Respiratory
- Wheezing Yes No
- Frequent cough Yes No
- Shortness of breath Yes No
- Other_____

Allergic/Immunologic
- Hay Fever Yes No
- Drug Allergies Yes No
- Other_____

Integumentary
- Skin rash Yes No
- Boils Yes No
- Persistent itch Yes No
- Other_____

Hematologic/Lymphatic
- Swollen glands Yes No
- Blood clotting problem Yes No
- Other_____

Neurological
- Tremors Yes No
- Dizzy spells Yes No
- Numbness/tingling Yes No
- Other_____

Musculoskeletal
- Joint pain Yes No
- Neck pain Yes No
- Back pain Yes No
- Other_____

Psychologic
- Memory loss/confusion Yes No
- Anxiety Yes No
- Depression Yes No
- Other_____

Endocrine
- Excessive thirst Yes No
- Too hot/cold Yes No
- Tired/sluggish Yes No
- Other_____

Ear/Nose/Throat/Mouth
- Ear infection Yes No
- Sore throat Yes No
- Sinus Problem Yes No
- Other_____

I authorize release of information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims of insurance benefits.

X____________________

Patient (or Guardian) Signature Date

ATLANTIC COAST UROLOGY, PA
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PATIENT INFORMATION

Name____ SS#_______________________
FIRST MI LAST

Mailing Address_______________________________________ City_____________________

State_______________ Zip_______________ Date of Birth_______________ Male_________ Female_________

Home Phone(___)__________ **Cell Phone (___)**_______________ Work Phone(___)_______________

Please check appropriate space: Minor_____ Single_____ Married_____ Widowed_____ Divorced_____

Patient's pf Parent's Employer____

Business Address____

Spouse or Parent's Name____

Are you, parent or spouse currently an active member of the military? Yes_____ No_____ If yes please indicate name, relationship, branch of service____

Whom may we "thank" for sending you?____

Allergies?____
DRUGS-FOODS

Person to contact in case of emergency____

Relationship_______________________________________ Phone(___)_______________

RESPONSIBLE PARTY

Person responsible for this account_______________________________ Relationship_______________
Employer_______________________________________ Phone(___)_______________
Birthdate_______________ SS#_______________ Work Phone(___)_______________

INSURANCE INFORMATION

Please give your insurance cards to our staff so we can make a copy of them.

PRIMARY INSURANCE

Company____

Insurance Company Address____

Name of Insured_______________________________________ Relationship to Insured_______________

SS# of Insured_______________ ID#_______________ Group_______________

How much is your deductible?_______________ Insured date of birth?_______________

Primary Physician_______________________________ Is this a managed care program(HMO)? Yes_____ No_____

Primary Physicians Address____

Primary Physicians Phone(___)_______________________ Group Name_______________________

Pharmacy Name____Phone(___)________________________

Pharmacy Address.____

SECONDARY INSURANCE

Company____

Insurance Company Address____

Name of Insured_______________________________________Relationship to Insured___________

SS# of Insured_________________________________ID#_______________________Group___________

Name of Employer____Phone(___)___________

How much is your deductible?________________________ Insured date of birth?_______________

Primary Physician_________________________________Is this a managed care program(HMO)? Yes___No___

Primary Physicians Address____

Primary Physicans Phone(___)______________________________Group Name_______________________

TO OUR PATIENTS:

Our office will attempt you with the completion of your insurance claim. However, each patient, not the insurance company, is responsible for payment to this office. Our office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim.

Due to the increasing completity of insurance policies with regard to PRE-CERTIFICATION, ASSISTANT SURGEON, SECOND OPINIONS, tec., for hospital stays and operations, YOU ARE RESPONSIBLE for notifying your insurance company before being admitted to the hospital. This will help avoid unnecessary denials or lowering of payment for failing to follow the OBLIGATIONS of YOUR POLICY.
We cannot be responsible for any loss of benefits. It is YOUR RESPONSIBILITY TO KNOW YOUR POLICY.
The doctors of Atlantic Coast Urology have a financiall interest in the following facilities; Shore OutPatient Surgicenter, Shore Point Radiation Oncology, Shrewsbury Surgicenter, **Center for Ambulatory Minimally Invasive Surgery**

Authorization & Release

I, the undersigned, hereby authorize payment of medical benefits to ATLANTIC COAST UROLOGY, PA for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract.

I authorize release of information concerning my (or my child's) health care, advise, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

X____
Signature of patient(or parent if minor) Date

MEDICARE LIFETIME SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made on *my behalf to ATLANTIC COAST UROLOGY, PA for any services furnished me by the physician. I authorize any* holder of medical infomation about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

X____
Signature PHOTO COPY AS VALID AS ORIGINAL Date

ASSURANCE OF PRIVACY FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem or improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We realize there is always room for improvement! It is our policy to listen to our employees and our patients. If you feel your privacy has been compromised in any way, please ask to speak with our compliance officer or express your concern to your physician.

Please read the following "Notice of Privacy." After reading, sign and return this form to the receptionist. If you have any questions, please ask. Thank you.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that the personal health information (PHI) is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing patient health information that is needed to carry out proper treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum amount of necessary information to only those we feel are in need of your health care information. **We strive to provide the best health care that is in <u>your</u> best interest.**

We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties you do not want PHI released to please tell our compliance officer and it will be documented in your chart. If there is any party that is not directly connected to your treatment, payment, or health care operations that you would like to have your PHI released to, please fill in their name(s) and relationship in the section below.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our compliance officer. You have the right to review our entire privacy policy manual upon request. Please sign this form to acknowledge that you have read this patient notice of privacy.

<u>Persons authorized to receive information</u>

______________________________ Relationship______________

______________________________ Relationship______________

Patient Name: ______________________________

Signature: ______________________________ Date: ______________

If minor, signature of parent or guardian: ______________________________

Thank you for being one of our highly valued patients.

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<u>For office use only</u>

A "good faith effort" was made to get a signature from patient, guardian, caretaker. Signature was not attained due to the following: ______________________________

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Matthew S. Tobin, MD, FACS
Diplomate, American Board of Urology
Medea A. Rueda-Macaluso, ANP
Ilona Poley, PA-C

PATIENT REGISTRATION ADDENDUM

Due to the many HMO & PPO plans that this office participates in, I understand that it is my responsibility to inform Atlantic Coast Urology,PA and associates at each visit of any insurance coverage. If I fail to do so, I understand that I may be responsible for the charges.

I understand that it is my responsibility to bring a referral at the time of any visit when a referral is required and it is my responsibility to certify any hospital or emergency room admission. I understand that I am responsible for any co-insurance, co-pay or deductible due at the time of service. I am responsible for all charges that are not covered by my insurance carrier.

Patient
Signature:_________________________________ Date:___________________

Jersey Shore Medical Arts Bldg * 1944 Corlies Ave. * Suite 101 * Neptune, NJ 07753 * (732)775-8444 * Fax (732) 775-8550
Professional Arts Center * 525 Jack Martin Blvd. * Suite 304 * Brick, NJ 08724 * (732) 840-6606 * Fax (732) 840-6601

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Attention Patients:

During your visit procedure, your doctor may remove specimen(s) and send them to Genesis Laboratory Management, LLC.

After the laboratory submits the claim, your insurance company is going to send you an explanation of benefits and possibly a check. Here is what you should do:

- Ignore the portion of the Explanation of Benefits that lists the "subscriber responsibility", "subscriber liability", "patient responsibility", "patient liability", etc...

  A balance listed in that area does not mean that the provider is going to bill you for that amount. This paperwork is not a bill and any balance listed as your responsibility is the portion of the claim your insurance company refuses to pay.

- If you receive a check for the lab, please send the check to:

Genesis Laboratory Management, LLC
1912 Route 35 South – Suite 202
Oakhurst, NJ 07755

If you have any questions or concerns, please contact the lab's billing company, Metropolitan Healthcare Billing, LLC. Their phone number is 732-389-8400 and their friendly staff would be more than happy to assist you Monday through Friday during normal business hours. If you need immediate attention after hours, you can e-mail the supervisor at: mmalmstrom@metrohealthbill.net and she will get back to you as soon as possible.

Thank you

The Office of Atlantic Coast Urology, PA

Patient Confirmation of receipt:____

ATLANTIC COAST UROLOGY, PA

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Please kindly provide us with your email address. Thank you!

Patient Name:

____

Email Address:

____

Date of Birth:

____

International Prostate Symptom Score (I-PSS)

Patient's Name ____________________ Date of Birth ______________ Date Completed ______________

	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	Your score
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining Over the past month, 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 times or more**	
7. Nocturia Over the past month, how many times 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	
Total I-PSS Score							

	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
Quality of Life Due to Urinary Symptoms If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

The International Prostate Symptom Score (I-PSS) is based on the answers to seven questions concerning urinary symptoms. Each question allows the patient to choose one of six answers indicating increasing severity of the particular symptom. The answers are assigned points from 0 to 5. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic). Furthermore, the International Scientific Committee recommends the use of a question to assess the quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of benign prostatic hyperplasia (BPH) symptoms or quality of life, it may serve as a valuable starting point for doctor-patient conversation.

The International Scientific Committee recommends that all physicians who counsel patients suffering from symptoms of prostatism utilize these measures not only during the initial interview but also during and after treatment in order to monitor treatment response.

The International Scientific Committee, under the patronage of the World Health Organization (WHO) and the International Union Against Cancer (UICC), has agreed to use the symptom index for BPH, which has been developed by the American Urological Association (AUA) Measurement Committee, as the symptoms assessment tool for patients suffering from prostatism.

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: ______________________ **TODAY'S DATE:** ____________

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No Sexual Activity	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than half the time)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (much less than half the time)	Sometimes (about half the time)	Most Times (much more than, half the time)	Almost Always or Always
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. TOTAL: ____________

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED 8-11 Moderate ED 12-16 Mild to Moderate ED 17-21 Mild ED