

**Main Urology Associates, P.C.**

Brompton Professional Park  
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-----Practice Limited to Urology\*Office Hours by Appointment-----

**Appt. Date:**

**Location:**

**WELCOME TO MAIN UROLOGY**

Thank you for calling our office for an appointment. In order to serve you more efficiently on the day of your appointment we ask that you:

- 1) Fill out the enclosed patient information forms.**
- 2) Bring the completed forms with you on your appointment date. Your picture will be taken at the time of your appointment for identification purposes.**
- 3) Bring your insurance cards. If your insurance requires a referral, you must have it on the day of your appointment, or your appointment will be rescheduled.**
- 4) Be prepared to pay a copay if your insurance so requires.**
- 5) Failure to complete the patient information forms will cause a delay in your appointment time.**

We are looking forward to participating in your good health.

Acct #

Main Urology Associates, P.C. Telephone: 631-0932  
Fax: 631-2826

Pat Whole Name (Last Name First)

Pat DOB

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone # \_\_\_\_\_ Cell# \_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Race \_\_\_\_\_ Soc.Sec.No. \_\_\_\_\_

Referring MD \_\_\_\_\_ Family MD \_\_\_\_\_

Dr's address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer Name, Address and Telephone \_\_\_\_\_

**Emergency Notification**

Name \_\_\_\_\_ Relation to patient \_\_\_\_\_

Telephone Work \_\_\_\_\_ Home \_\_\_\_\_

**Insurance Information**

Type of Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Policy Holder \_\_\_\_\_ D.O.B. \_\_\_\_\_

Place of Employment of Insured \_\_\_\_\_

It is necessary for us to have written consent in your medical file if you want us to be able to communicate any medical information about yourself to another individual. If you want us to release information to a family member, such as a spouse, significant other, a parent or a sibling, or any other individual, you must indicate the name of the person(s). WE WILL BE UNABLE TO RELEASE ANY INFORMATION TO ANYONE OTHER THAN WHO IS INDICATED ON THIS FORM.

I, \_\_\_\_\_, hereby give my permission for the staff of  
(Your Name)

Main Urology Associates to release medical information about myself to:

\_\_\_\_\_  
(Name of person you are authorizing) (Relationship) (phone number)

\_\_\_\_\_  
(Name of person you are authorizing) (Relationship) (phone number)

I may cancel this authorization at any time by written notification.

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Acct #

NEW PATIENT HISTORY

The reason you are seeing the doctor today: \_\_\_\_\_

Allergies: Drug or Environmental "Example" - Shellfish or IVP Dye

None: \_\_\_\_\_ List: \_\_\_\_\_

Medications (including Aspirin/Vitamins Etc.): \_\_\_\_\_

Pharmacy name and telephone#: \_\_\_\_\_

Personal Medical History (please circle any of the following which you have)

- |                      |                             |                       |
|----------------------|-----------------------------|-----------------------|
| AIDS                 | Emphysema                   | Meningitis            |
| Anemia               | Epilepsy                    | MI                    |
| Angina               | Genital Herpes              | Mitral Valve Prolapse |
| Arthritis            | Glaucoma                    | Parkinson             |
| Asthma               | Heart Disease               | Peptic Ulcer          |
| Cancer               | Heart Murmur                | Pneumonia             |
| Cataract             | Heart Valve Replacement     | Radiation Therapy     |
| Chemotherapy         | Hemophilia                  | Sickle Cell Disease   |
| Cholesterol Elevated | Hepatitis                   | Sinus Pain            |
| Depression/Anxiety   | High Blood Pressure         | Stroke                |
| Diabetes             | Joint Replacement(hip/knee) | Thyroid Disease       |
| Diverticulosis       | Kidney Stones               | Tuberculosis          |
|                      |                             | Venereal Disease      |

Other: \_\_\_\_\_

Other specialist(s) you see (ie: cardiologist, nephrologist, neurologist, rheumatologist, oncologist, hematologist etc). Please list name and address (use back of paperwork if necessary):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you wear glasses or contacts? Yes No

Are you hard of hearing? Yes No

Do you smoke? Yes No #PPD \_\_\_\_\_ #Years \_\_\_\_\_

Do you drink alcohol? Yes No Occasionally Rarely

Do you take antibiotics before dental work/or do you have an artificial implant? Yes No

Pat Whole Name (Last Name First)

Pat DOB

Acct #

NEW PATIENT HISTORY CONT

Women: Are you pregnant? Yes No #Weeks \_\_\_\_\_  
Last Menstrual Period? \_\_\_\_\_  
Number of Pregnancies? \_\_\_\_\_  
Number of Deliveries \_\_\_\_\_

Family history of prostate/bladder/kidney cancer? Yes No  
Sexual function: Difficulty obtaining erection, difficulty maintaining erection,  
erection inadequate for intercourse? Yes No

List all past surgery with approximate date or age and any other  
medical/surgical history NOT Listed: \_\_\_\_\_  
\_\_\_\_\_

Pat Whole Name (Last Name First) \_\_\_\_\_ Pat DOB \_\_\_\_\_

Acct #

**ACKNOWLEDGMENT OF RECEIPT OF  
Main Urology Associates, P.C.  
Notice of Privacy Practices**

I, **Pat Whole Name (Last Name First)** was provided by  
**Main Urology Associates, P.C. Notice of Privacy Practices** either:

\_\_\_\_\_ Upon my first visit for treatment.

\_\_\_\_\_ Via e-mail with my permission before my first visit for treatment.

\_\_\_\_\_ In an emergency situation, as soon as possible after the emergency treatment situation.

\_\_\_\_\_ Print Patient's Name

\_\_\_\_\_ Patient's Signature

\_\_\_\_\_ Date

\*\*\*\*\*

**If the patient did not sign the Acknowledgment, please state:**

**Efforts made to obtain Acknowledgment:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Reasons for not obtaining Acknowledgment:**

\_\_\_\_\_ Patient or patient's representative refused to sign

\_\_\_\_\_ An emergency situation prevented patient from signing Acknowledgment

\_\_\_\_\_ Other:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_