

Central Arizona Urologists, Ltd.

CONFIDENTIAL

Please **PRINT** and complete **ALL** information **IN FULL** (Note: This information is only used for your protection)

Name: _____ Date: _____
First Middle Last

Date of Birth: _____ - _____ - _____ Social Security #: _____ - _____ - _____

Home Phone #: (_____) _____ Work Phone #: (_____) _____

Cell Phone #: (_____) _____ E-Mail Address: _____

State ID/Driver's License #: _____ Issuing State: _____

Marital Status: Married Single Widowed Divorced Name of Spouse: _____ Number of Children: _____

Mailing Address: _____
Street Number Apt. # City State Zip

Patient's Employer: _____

Primary Care/Referring Physician : _____
First M.I. Last MD NP DO PA-C Phone #: (_____) _____

Nearest Relative: _____ Relationship: _____ Phone #: (_____) _____
Not Living at Same Address

Insurance Information:

Primary: _____ ID#: _____ Group #: _____

Insured Name: _____ Insured's Social Security #: _____ - _____ - _____

Insured's Employer: _____ DOB of Insured _____ - _____ - _____

Secondary: _____ ID#: _____ Group #: _____

Insured Name: _____ Insured's Social Security #: _____ - _____ - _____

Insured's Employer: _____ DOB of Insured _____ - _____ - _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to James R. Fishman, M.D., M. Michael Hayyeri, M.D., and any associates of the surgical and/or medical benefits, if any, otherwise payable to me for services rendered to me or my dependent. I also authorize my doctor to release information regarding my treatment. I understand that I am financially responsible for all charges.

Patient Signature Date

HIPAA Notification:

I acknowledge that Central Arizona Urologists are in compliance with HIPPA laws regarding the Notice of Privacy Practices. This notice describes how Central Arizona Urologists may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I understand these policies are posted within the office and a copy of these policies is available upon my request.

According to these policies, I understand that unless written permission is given patient information can only be released to the patients themselves. In compliance with these policies, I hereby entitle authorization for my personal information to be discussed with the following people:

Name Relationship Phone #

OK to leave voicemails at Home Phone #

OK to leave voicemails on cell Phone #

Signature of Patient Date Staff Initials Date

Cancellation Policy: I understand when I make an appointment, the physician, provider and staff are scheduled for my care. I agree to pay a \$50 fee if I miss my scheduled appointment or not cancel 24 hours in advance. Please initial _____

MEDICAL AND SURGICAL HISTORY

I. For what medical condition are you consulting a urologist? _____

II. Past Medical and Surgical History:

A. Surgeries	Hospital	Surgeon	Year
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

B. Medical Illnesses	Yes	No		Yes	No
1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
2. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis <input type="checkbox"/> A / <input type="checkbox"/> B / <input type="checkbox"/> C	<input type="checkbox"/>	<input type="checkbox"/>
3. Lung Disease (COPD)/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
5. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>
6. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Acid reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>
7. Gastrointestinal Disease (Ulcers, Diverticulitis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid <input type="checkbox"/> High/ <input type="checkbox"/> Low	<input type="checkbox"/>	<input type="checkbox"/>
8. Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
9. Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
10. HIV	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

III. Medications (Including aspirin and vitamin/herbal)

Name	Dosage	Frequency	
1. _____			5. _____
2. _____			6. _____
3. _____			7. _____
4. _____			8. _____

IV. Allergies (to any medications or tapes) No Yes

Name	Reaction	
1. _____		5. _____
2. _____		6. _____
3. _____		7. _____

V. Family History

	Living	Deceased	Illnesses	Age & Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sisters	# <input type="checkbox"/>	# <input type="checkbox"/>	_____	_____
Brothers	# <input type="checkbox"/>	# <input type="checkbox"/>	_____	_____

VI. Family History of the Following:

1. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	4. Cancer(s)	<input type="checkbox"/>	<input type="checkbox"/>	7. Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
2. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	8. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Prostate Disease	<input type="checkbox"/>	<input type="checkbox"/>	6. Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>			

VII. Social Habits

1. Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Amount (packs/day) _____ How many years? _____ When did you quit? _____
2. Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Any drugs (illicit)?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Any caffeine use?	<input type="checkbox"/>	<input type="checkbox"/>	
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	
Tea	<input type="checkbox"/>	<input type="checkbox"/>	
Sodas	<input type="checkbox"/>	<input type="checkbox"/>	
5. Any blood transfusions?	<input type="checkbox"/>	<input type="checkbox"/>	

VIII. Do you have any of these symptoms?

	Yes	No		Yes	No		Yes	No
1. Constit.			5. Resp.			9. Neurological		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Wt. Loss	<input type="checkbox"/>	<input type="checkbox"/>	Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	10. Psychiatric		
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Breathing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
2. Eyes			6. GI.			Change in Personality	<input type="checkbox"/>	<input type="checkbox"/>
Vision Blurring	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	11. Endocrine		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to Heat	<input type="checkbox"/>	<input type="checkbox"/>
3. ENT.			Belly Pain	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Constant Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Blood Stool	<input type="checkbox"/>	<input type="checkbox"/>	12. Hematologic/Lymphatic		
4. Cardiovascular			7. Musculo-skeletal			Lymph Node Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>			
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	8. Integumentary					
Swelling of Legs	<input type="checkbox"/>	<input type="checkbox"/>	Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>			



Office Use ONLY

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IX. History of Present Illness

Date of Service: _____

X. Physical Exam: Check box within normal limits

1. CONST. T _____ P _____ BP _____ RESP _____ HT _____ W _____

GEN APPEARANCE: Good Nutrition Normal Body Habits Normal Grooming

2. HEENT. EYES ENT NC/AT PERRLA

3. NECK NECK No Masses Symmet Trach Midline Supple

THYROID Not Enlarged No Masses No Tenderness

4. RESP RESP EFFORT No Auscultation Normal Diaph Mvt. CTA

5. CV AUSCULTATION No Murms Normal Rhythm

PERIPHERAL VASCULAR No Edema No Varic. Normal Pulses

6. G.I. ABDOMEN No Masses BS+ NT ND No CVAT No Hernia No HSM No SPT

7. EXT. No C/C/E