

MARITAL INFORMATION:

Please circle one: Single Married Divorced Widowed

If you are married or your divorced spouse is the policy holder of your health insurance, please complete the following information:

Name of Spouse: _____ Date of Birth: _____

Employer: _____ Social Security #: _____

Employer's address: _____

Employer's telephone #: _____

Nearest Relative not living with you: _____

Relationship: _____ Telephone: _____

Whom may we contact in case of emergency: _____

Relationship: _____ Telephone: _____

If you are being seen for workmen's compensation or a legal case:

Name of Insurance Company: _____

Name & address of attorney: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Urological Associates of Bridgeport, P.C. to furnish information to insurance carriers concerning illness and treatments of the above named patient, and hereby assign to the physicians all payments for medical/surgical services rendered. I am responsible for fee amounts not covered by insurance.

Signature: _____ Date: _____

I accept full responsibility for payment of all services rendered by Urological Associates of Bridgeport, P.C. In addition, I agree to pay any costs of collection including reasonable attorney fees. I have read and agreed to abide by the policies of Urological Associates of Bridgeport P.C. as noted below.

Signature: _____ Date: _____

PATIENT INFORMATION FORM

Date _____

PRIMARY CARE PHYSICIAN _____

REFERRED BY _____

PATIENT'S NAME: _____ AGE: _____
(last) (first) (m)

ADDRESS: _____
(street or P.O. Box) (apt #) (city, state, zip)

HOME TELEPHONE: _____ Date of Birth: _____

EMAIL ADDRESS _____

WORK TELEPHONE #: _____ Ext. ____ Cell Phone #: _____

EMPLOYER: _____ Social Security #: _____

EMPLOYER'S ADDRESS: _____
(street or P.O. Box) (city, state, zip)

INSURANCE INFORMATION: *(please provide your insurance card to the receptionist)*

Primary Insurance:

Secondary Insurance:

Name of Ins. Co.: _____

Address of Ins. Co.: _____

Policy Number: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

MEDICAL INFORMATION:

Allergy to medication or iodine X-ray dye: _____

Current Medications: _____

INSURANCE INFORMATION: (Please provide your insurance card to the receptionist)

Primary Insurance: Secondary Insurance:

Name of Ins. Co.: _____

Address of Ins. Co.: _____

Policy Number: _____

Policy Holder's Name: _____

Policy Holder's D.O.B. _____

If you are being seen for workman's compensation or legal case:

Name of insurance company: _____

Name & address of attorney: _____

INSURANCE AUTHORIZATION & ASSIGNMENT

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Signature: _____ Date: _____

Method of payment today: Cash _____ Check _____ Credit Card _____

I accept full responsibility for payment of all services rendered by Urological Associates of Bridgeport, P.C. In addition, I agree to pay any costs of collection including reasonable attorney fees. I have read and agree to abide by the policies of Urological Associates of Bridgeport, P.C. as noted below.

SIGNATURE: (of patient or parent if minor) _____

DATE _____

PATIENT INFORMATION FORM
Under 18 years of age or a dependant

Patient's name: _____ Age: _____
(last) (first) (m)

Address: _____
(street or P.O. Box) (apt. #) (city, state, zip)

Telephone #: _____ Date of Birth: _____

Parents are (please circle one): married separated divorced

Father: _____ Mother: _____

Name: _____

Address: _____

Home telephone #: _____

Cell #: _____

Date of birth: _____

Social Security #: _____

Employer: _____

Employer address: _____

Employer Telephone #: _____

Allergy to medication or iodine X-ray dye: _____

Current Medications: _____

Referred by: _____ Family Doctor: _____

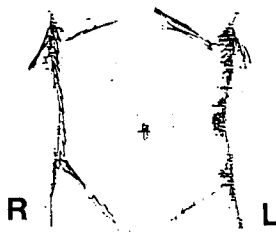
Nearest relative not living with you: _____

Relationship: _____ Telephone #: _____

Whom may we contact in case of emergency: _____

Relationship: _____ Telephone #: _____

FEMALE

<p>★ Constitutional: (3/6)</p> <p>Vital Signs: _____</p> <p>Appearance: _____ NL</p>	<p>BP: _____ T _____ P _____ R _____ HT _____ WT _____</p> <p>Development: _____ Nutrition: _____ Deformities _____ Grooming _____</p>
<p>★ Gastrointestinal:</p> <p>Abdomen: _____ NL</p> <p>Bladder/Kidneys: _____ NL</p> <p>Liver/Spleen: _____ NL</p> <p>Hernia: _____ Absent</p> <p>Stool Specimen: _____ NL</p>	<p>Mass: _____ Size: _____ Shape: _____ Consistency: _____</p> <p>Tenderness: RUQ _____ LUQ _____ RLQ _____ LLQ _____ Distended: _____</p> <p>Rigidity: _____ Rebound: _____ Guarding: _____</p> <p>Inguinal: _____ R/L Femoral: _____ R/L Ventral: _____</p> <p>Not Indicated: _____ Collected: _____ Pos/Neg Guaiac _____</p> 
<p>★ Genitourinary: (7/10)</p> <p>DRE: _____ NL</p> <p>External genitalia: _____ NL</p> <p>Meatus: _____ NL</p> <p>Urethra: _____ NL</p> <p>Bladder: _____ NL</p> <p>Vagina: _____ NL</p> <p>Cervix: _____ NL</p> <p>Uterus: _____ NL</p> <p>Adnexa: _____ NL</p> <p>Anus/Perineum: _____ NL</p>	<p>Tone: _____ Mass: _____ Hemorrhoids: _____ Other: _____</p> <p>Lesions: _____ Rash: _____ Cysts: _____ Condyloma: _____ Atrophy: _____ Other: _____</p> <p>Small: _____ Large: _____ Retracted: _____ Caruncle: _____</p> <p>Discharge: _____ Other: _____</p> <p>Hypermobility: _____ Leakage w/stress: _____ Tenderness: _____</p> <p>Diverticuli: _____ Masses: _____ Scarring: _____</p> <p>Mass: _____ Fullness: _____ Soft: _____ Firm: _____ Mobile: _____</p> <p>Cystocele/Degree: _____ Rectocele/Degree: _____ Enterocoele/Degree: _____</p> <p>Inflamed: _____ Discharge: _____ Lesions: _____ Size: _____ Loc'n: _____</p> <p>Size: _____ Irregular: _____ Position: _____ Mobility: _____ Descent: _____ Mass: _____</p> <p>Tenderness: _____ Ovaries: _____ Size: _____ Mass: _____ Fixed: _____</p> <p>Fissures: _____ Dimples: _____ Tenderness: _____ Other: _____</p>
<p>Back:</p> <p>Back: _____ NL</p>	<p>CVAT: _____ Rt/Lt Dimples: _____ Coccyx: _____ Hair tufts: _____</p>
<p>Neurologic/Psychiatric:</p> <p>Orientation: _____ NL</p> <p>Mood/Affect: _____ NL</p>	<p>Time: _____ Place: _____ Person: _____ Other: _____</p> <p>Depression: _____ Anxiety: _____ Agitation: _____ Somnolent: _____ Other: _____</p>
<p>Skin:</p> <p>Inspection: _____ NL</p> <p>Palpation: _____ NL</p>	<p>Pale: _____ Jaundice: _____ Cyanosis: _____ Turgor: _____ Other: _____</p> <p>Hydration: _____ Texture: _____ Rash: _____ Lesions: _____ Other: _____</p>
<p>Neck:</p> <p>Neck: _____ NL</p> <p>Thyroid: _____ NL</p>	<p>Symmetry: _____ Swelling: _____ Tenderness: _____ Other: _____</p> <p>Size: _____ Tenderness: _____ Nodules: _____ Other: _____</p>
<p>Respiratory:</p> <p>Effort: _____ NL</p> <p>Auscultation: _____ NL</p>	<p>Labored: _____ Diaphragmatic: _____ Abdominal: _____</p> <p>Rales: _____ Rhonchi: _____ Wheezing _____ Rubs: _____</p>
<p>Cardiovascular:</p> <p>Auscultation: _____ NL</p> <p>Peripheral: _____ NL</p>	<p>Rhythm: _____ Murmurs: _____ Rubs: _____ Other: _____</p> <p>Swelling: _____ Varicosities: _____ Pedal pulse: _____ Temperature: _____</p> <p>Tenderness: _____ Other: _____</p>
<p>Lymph Nodes:</p> <p>Palpable: _____ NL</p>	<p>Inguinal: _____ Femoral: _____ Cervical: _____ Clavicular: _____ Other: _____</p>

UA Urological Associates

Of Bridgeport, P.C.

Advanced Urologic Care

Nicholas A. Viner, MD
 Howard L. Zuckerman, MD
 Arthur C. Pinto, MD, FACS
 Edward B. Paraiso II, MD
 Robert P. Weinstein, MD
 Jeremy D. Kaufman, MD
 Linda Gale, PA-C

Name _____
 Address _____
 Home # _____ Cell # _____
 Consult requested by: _____

Date _____
 DOB _____ Age _____
 Insurance _____
 PCP: _____

FEMALE

HISTORY: _____

location _____
 quality _____
 duration _____
 severity _____
 timing _____
 context _____

VOIDING Hx: Frequency: Y / N Intermittency: Y / N Incomplete emptying: Y / N SUI: Y / N
 Urgency: Y / N Hesitancy: Y / N Hematuria: Y / N UI: Y / N
 UTI's: Y / N STD'S: Y / N Urolithiasis: Y / N #pads/day _____
 Nocturia: _____/night FOS: weak/moderate/strong Dysuria: Y / N

MEDICAL Hx: None HTN DM CAD CVA COPD coagulopathy ↑cholesterol
 Other: _____

SURGERY: _____

ALLERGY: NKDA _____

MEDS: _____

SOCIAL: Tobacco: Y/N
 _____ PPD X _____ yrs.
 quit X _____ yrs.

ETOH: Y/N AMOUNT: _____
 Occupation: _____
 Chemical exposures: _____

FAMILY Hx: None CAP Stones DM CAD Other: _____

REVIEW OF SYSTEMS: Reviewed: _____


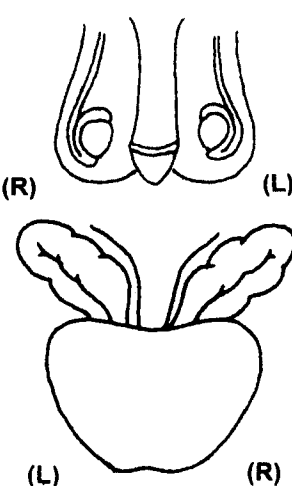
TESTS: _____ LABS: _____

URINALYSIS: pH _____ Sugar _____ Protein _____ Ketones _____ Blood _____ LE _____ Nitrites: _____
 Micro: WBC _____ RBC _____ Bacteria _____ Epithelial cells _____ Crystals _____
 Indication: _____ Catheterized/Voided

IMPRESSION:
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____

PLAN:
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____
 Signature _____ Date _____

MALE

<p>★ Constitutional: (3/6)</p> <p>Vital Signs: _____</p> <p>Appearance: _____ NL</p>	<p>BP: _____ T _____ P _____ R _____ HT _____ WT _____</p> <p>Development: _____ Nutrition: _____ Deformities _____ Grooming _____</p>
<p>★ Gastrointestinal:</p> <p>Abdomen: _____ NL</p> <p>Bladder/Kidneys: _____ NL</p> <p>Liver/Spleen: _____ NL</p> <p>Hernia: _____ Absent</p> <p>Stool Specimen: _____ NL</p>	<p>Mass: _____ Size: _____ Shape: _____ Consistency: _____</p> <p>Tenderness: RUQ _____ LUQ _____ RLQ _____ LLQ _____ Distended: _____</p> <p>Rigidity: _____ Rebound: _____ Guarding: _____</p> <p>Inguinal: _____ R/L Femoral: _____ R/L Ventral: _____</p> <p>Not Indicated: _____ Collected: _____ Pos/Neg Guaiac _____</p> 
<p>★ Genitourinary: (7/10)</p> <p>Anus/Perineum: _____ NL</p> <p>Scrotum: _____ NL</p> <p>Epididymes: _____ NL</p> <p>Spermatic cord: _____ NL</p> <p>Testis: _____ NL</p> <p>Meatus: _____ NL</p> <p>Penis: _____ NL</p> <p>Prostate: _____ NL</p> <p>Seminal Vesicles: _____ NL</p> <p>Sphincter tone: _____ NL</p>	<p>Fissures: _____ Dimples: _____ Tenderness: _____</p> <p>Lesions: _____ Rash: _____ Cysts: _____</p> <p>Enlarged: _____ Indurated: _____ Tender: _____ Mass: _____ Spermatocoele: _____</p> <p>Varicocoele: _____ Rt/Lt; Grade: _____ Vas: _____</p> <p>Tender: _____ Symmetry: _____ Hydrocoele: _____ Mass: _____ Size: _____</p> <p>Small: _____ Large: _____ Hypospadias: _____</p> <p>Lesion: _____ Polyp: _____ Discharge: _____</p> <p>Circumcised: _____ Phimosis: _____ Peyronies: _____</p> <p>Condyloma: _____ Lump: _____</p> <p>Size 1+ _____ 2+ _____ 3+ _____ 4+ _____ Nodules: _____</p> <p>Symmetry: Rt > Lt _____ Lt > Rt _____ Boggy: _____ Firm: _____ Hard: _____</p> <p>Symmetrical: _____ Irregular: _____ Tender: _____ Indurated: _____</p> <p>Poor: _____ Hemorrhoids: _____ Mass: _____ Size: _____</p> 
<p>Back:</p> <p>Back: _____ NL</p>	<p>CVAT: _____ Rt/Lt Dimples: _____ Coccyx: _____ Hair tufts: _____</p>
<p>Neurologic/Psychiatric:</p> <p>Orientation: _____ NL</p> <p>Mood/Affect: _____ NL</p>	<p>Time: _____ Place: _____ Person: _____ Other: _____</p> <p>Depression: _____ Anxiety: _____ Agitation: _____ Somnolent: _____ Other: _____</p>
<p>Skin:</p> <p>Inspection: _____ NL</p> <p>Palpation: _____ NL</p>	<p>Pale: _____ Jaundice: _____ Cyanosis: _____ Turgor: _____ Other: _____</p> <p>Hydration: _____ Texture: _____ Rash: _____ Lesions: _____ Other: _____</p>
<p>Neck:</p> <p>Neck: _____ NL</p> <p>Thyroid: _____ NL</p>	<p>Symmetry: _____ Swelling: _____ Tenderness: _____ Other: _____</p> <p>Size: _____ Tenderness: _____ Nodules: _____ Other: _____</p>
<p>Respiratory:</p> <p>Effort: _____ NL</p> <p>Auscultation: _____ NL</p>	<p>Labored: _____ Diaphragmatic: _____ Abdominal: _____</p> <p>Rales: _____ Rhonchi: _____ Wheezing _____ Rubs: _____</p>
<p>Cardiovascular:</p> <p>Auscultation: _____ NL</p> <p>Peripheral: _____ NL</p>	<p>Rhythm: _____ Murmurs: _____ Rubs: _____ Other: _____</p> <p>Swelling: _____ Varicosities: _____ Pedal pulse: _____ Temperature: _____</p> <p>Tenderness: _____ Other: _____</p>
<p>Lymph Nodes:</p> <p>Palpable: _____ NL</p>	<p>Inguinal: _____ Femoral: _____ Cervical: _____ Clavicular: _____ Other: _____</p>

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Name _____
Address _____
Home # _____ Cell # _____
Consult requested by: _____

Date _____
DOB _____ Age _____
Insurance _____
PCP: _____

MALE

HISTORY: _____
location _____
quality _____
duration _____
severity _____
timing _____
context _____

VOIDING Hx: Frequency: Y / N Intermittency: Y / N Incomplete emptying: Y / N Hematuria: Y / N
Urgency: Y / N Hesitancy: Y / N Straining: Y / N Dysuria: Y / N
UTI's: Y / N STD'S: Y / N Urolithiasis: Y / N
Nocturia: _____/night FOS: weak/moderate/strong

MEDICAL Hx: None HTN DM CAD CVA COPD coagulopathy ↑cholesterol
Other: _____

SURGERY: _____

ALLERGY: NKDA _____

MEDS: _____

SOCIAL: Tobacco: Y/N
PPD X _____ yrs.
 quit X _____ yrs.
ETOH: Y/N AMOUNT: _____
Occupation: _____
Chemical exposures: _____

FAMILY Hx: None CAP Stones DM CAD Other: _____

REVIEW OF SYSTEMS: Reviewed: _____
TESTS: _____ **LABS:** _____

URINALYSIS: pH _____ Sugar _____ Protein _____ Ketones _____ Blood _____ LE _____ Nitrites: _____
Micro: WBC _____ RBC _____ Bacteria _____ Epithelial cells _____ Crystals _____
Indication: _____ Catheterized/Voided

IMPRESSION:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PLAN:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
Signature _____ Date _____

UROLOGICAL ASSOCIATES OF BRIDGEPORT, P.C.

160 HAWLEY LANE
TRUMBULL, CT 06611
TELEPHONE: 203-375-3456

NICHOLAS A. VINER, M.D.
HOWARD L. ZUCKERMAN, M.D.
ARTHUR C. PINTO, M.D. FACS
EDWARD B. PARAISO II, M.D.
ROBERT P. WEINSTEIN, M.D.
JEREMY D. KAUFMAN, M.D.
LINDA GALE, PA-C

Date _____

Authorization for Release of Medical Information:

I give my permission to release all medical records and/or X-Rays to the above physicians.

Patient's Name _____

Address _____

Date of Birth _____

X _____
Patient's Signature

X _____
Witness

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 may be 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 acknowledge that I have received your *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 its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy 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 not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

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

Date:	Initials:	Reason:
-------	-----------	---------

Confidential Communication Request
Urological Associates of Bridgeport P.C.
160 Hawley Lane, Trumbull, Ct. 06611
(203) 375-3456 Fax (203) 375-4456

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided. Please complete entire form.

I, _____ (print name) hereby request the use of confidential channels for the communication of information related to my personal health, treatment or payment for treatment.

Effective date/or/Date of Service for confidential communication:
From: _____ Thru: _____ Date of Service: _____

Please select all that apply:

Home Phone: _____
Work Phone: _____
Cell Phone: _____

Authorized persons (list names and relationship of authorized person with whom we may discuss your protected health information with. Name: _____

Circle Only One:

Relationship: Spouse Family Member Parent Friend Personal Representative

Describe below other means you may request for confidential communications.

In the event that I do not answer my phone: (circle your choices)

Leave a message on my : answering machine voice mail email _____

Patients Signature: _____ Date: _____

If this form was not completed by patient, please sign below and state relationship to patient:

Signature: _____

Relationship to Patient: Circle below

Parent Legal Guardian Conservator Patient Representative