

UROLOGY CENTER OF PALM BEACH, P.A.

Name _____ Date _____

Date of Birth _____ Age _____ Sex (circle one) M F

Social Security # _____

Marital Status (circle one) Married Divorced Single Widowed Separated

Home Address _____ City _____ Zip _____

Home Phone _____ Work/Cell Phone _____

Emergency Contact (NOT living with you)

Name _____ Relationship _____

Home Phone # _____ Work/Cell Phone _____

I heard about this practice from (check)

- Physician Newspaper Friends and/or family
 Yellow Pages Palm Beach Post Other

Referring Physician _____ Specialty _____

Phone # _____

Primary care Physician (if different from above)

_____ Phone # _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have been provided the opportunity to review Dr. Diego Rubinowicz's Notice of Privacy Practices.

Name _____ Date _____

Signature _____

.....

I have been provided an opportunity to review the Privacy Notice and **DO NOT** wish to sign the acknowledgment form.

SIGNATURE _____ DATE _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

I hereby authorize and assign payment to Urology Center of Palm Beach, P.A. for all insurance medical benefits. I also understand my responsibilities of payment for any and all charges not payable under this assignment. Payment, including copays, is also expected in full at the time services are rendered.

Urology Center of Palm Beach does NOT file claims with secondary insurances with the following exceptions: Medicare is the primary insurance and there is a supplemental insurance, Medicare/Medicaid is the secondary insurance. However, we will supply all the paperwork needed for the patient to submit the claim to his/her secondary insurance.

I understand and agree that, regardless of my insurance status, I am fully responsible for the balance of my account for any professional services rendered including any fees incurred for the collection of debt.

NO SHOW POLICY

I _____ understand that there will be a \$30.00 no show fee that I am fully responsible for if I do not call and cancel my appointment at least 24 hours in advance.

I understand that there will be a \$50.00 no show fee for any in-office missed/cancelled procedures without a 48-hour notice.

I understand that there will be a \$100 no show fee for any out-of-the-office missed/cancelled procedures without a 5 business day notice.

MALPRACTICE INSURANCE

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims in medical malpractice. This notice is provided pursuant to Florida law.

The undersigned patient acknowledges the receipt of the insurance information, no-show and malpractice insurance notices.

Patient's Signature

Printed Name

Date

UROLOGY CENTER OF PALM BEACH, P.A.

Age: _____

Date: ___/___/___

Name: _____

Reason for Visit:

Medical History (check if applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma/lung problems | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> sexually transmitted dis |

Other:

Surgeries: (list all)

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Family History: (check all applicable)

- | | |
|---|---|
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Bladder Cancer |
| <input type="checkbox"/> Other kidney disorders | <input type="checkbox"/> Prostate cancer (male patients only) |
| <input type="checkbox"/> Other: _____ | |

Medications:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Do you take any blood thinners such as aspirin, coumadin or plavix? Yes No

Allergies:

Do you have any of the following? Circle Yes or No

Fever	Yes	No	Shortness of breath	Yes	No
Chills	Yes	No	Coughing	Yes	No
Nausea	Yes	No	Wheezing	Yes	No
Vomiting	Yes	No			
Headache	Yes	No	Bleeding problems	Yes	No
Blurred Vision	Yes	No	Swollen glands	Yes	No
Double Vision	Yes	No			
Hay Fever	Yes	No	Bone Pain	Yes	No
			Back Pain	Yes	No
			Flank Pain	Yes	No
Tremors	Yes	No			
Dizziness	Yes	No	Blood in Urine	Yes	No
Numbness/Tingling	Yes	No	Slow Stream	Yes	No
			Frequency	Yes	No
Abdominal Pain	Yes	No	Urge to urinate	Yes	No
Heartburn	Yes	No	Unable to urinate	Yes	No
Diarrhea	Yes	No	Incontinence	Yes	No
			Sexual Problems	Yes	No
Chest Pain	Yes	No			
Palpitations	Yes	No			
Irregular Heartbeat	Yes	No			

Smoking:

_____ packs per day for _____ years

Cigars

Quit _____ years ago

Never smoked

Alcohol:

_____ drinks/beers per day for _____ years

Occasionally

Never

Recreational Drugs:

Have you ever had diseased heart valves, hip replacement or other prosthetic implants?

Yes No