ASSOCIATED MEDICAL PROFESSIONALS

Today's date_____

Please Print

A. PATIENT INFORMATION

Name (Last)_____(First)_____(M.I.)_____

Address _____
(Street) (City) (State) (Zip)

Home phone (____)_____Cell phone (___)_____ Work Phone (___)_____

E-mail Address: _____

Sex: M F DOB: ____/____/____ Age: _____ SS#: _____-_____-_____
(optional - Medicaid patients must fill out)

Marital Status: S M W D Language: _____

Race: ☐Caucasian ☐African American ☐Asian ☐American Indian ☐ Native Hawaiian ☐ Declined

Ethnicity: ☐Spanish/Hispanic Origin ☐Not of Spanish/Hispanic Origin ☐Decline to Answer

Occupation _____ Employer _____

Referring physician _____ Family Physician _____

Physicians seen regularly _____

Have you ever seen a urologist before? Y N If so who? _____

Pharmacy Name(Mail Order & Local)/Location _____ Phone (____)_____

Emergency Contact :Name _____ Relationship _____ Phone(____)_____

B. INSURANCE INFORMATION - We will need to copy your insurance cards

Primary Insurance _____ Insurance ID# _____ Group_____

Policy Holder _____ Policy Holder's DOB_____

Relationship to Patient _____

Employer _____ Occupation _____

Secondary Insurance _____ Insurance ID# _____ Group_____

Policy Holder _____ Policy Holder's DOB_____

Relationship to Patient _____

Employer _____ Occupation _____

C. INSURED'S INFORMATION OR DEPENDENT'S RESPONSIBLE PARTY

Name _____
(Last) (First) (M.I.)

Address _____
(Street) (City) (State) (Zip)

Home phone (____)_____Cell phone (___)_____ Work Phone (___)_____

ASSOCIATED MEDICAL PROFESSIONALS
AUTHORIZATION FOR RELEASE OF INFORMATION AND DIRECT PAYMENT

I hereby authorize Associated Medical Professionals to release my medical information necessary for filing claims for service carriers liable for such payments. I hereby authorize the insurance carriers to make payment of benefits directly to Associated Medical Professionals to act as my agent to help me secure payment from my insurance company. I understand that I am responsible for my bill.

Signature:_____Date:_____

Patient Name (PLEASE PRINT): _____

MEDICARE BENEFITS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information to release to the Social Security Administration or its carriers any information required to process my medical claim. I request that payment be made indefinitely to Associated Medical Professionals for services provided under the medical insurance program.

Signature:_____Date:_____

Patient Name (PLEASE PRINT): _____

PAYMENT TERMS: YOU ARE RESPONSIBLE FOR ANY COPAYMENTS (AT TIME OF SERVICE), DEDUCTIBLES OR UNCOVERED SERVICES. PAYMENT IS EXPECTED FOR SERVICES AT THE TIME THEY ARE RENDERED. THIS OFFICE WILL SUBMIT INSURANCE CLAIMS FOR CARRIERS ONLY.

IF THE PATIENT IS A MEMBER OF ANY INSURANCE COMPANY REQUIRING A REFERRAL, SUCH AS HEALTHSOURCE, HMO CNY, A VALID REFERRAL MUST BE ON FILE WITH THIS OFFICE AT THE TIME SERVICES ARE RENDERED OR THE PATIENT WILL BE RESPONSIBLE FOR THE BILL.

THE PATIENT AGREES TO PAY ALL COLLECTION CHARGES IF IT IS NECESSARY TO PURSUE PAYMENT OF THE ACCOUNT THROUGH A COLLECTION AGENCY.

PATIENT OR PARENT'S SIGNATURE_____DATE_____

Patient Name (PLEASE PRINT): _____

PLEASE NOTIFY RECEPTIONIST IF THIS IS WORKERS COMPENSATION OR NO FAULT

ASSOCIATED MEDICAL PROFESSIONALS
PATIENT HISTORY FORM

Today's Date: _____ Referring Physician: _____

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____Date of Birth:_____Height _____Weight _____

Please answer the following questions:
CHIEF COMPLAINT: What is the main reason for your visit today? (Describe your problem in detail)
_____
_____
_____
_____
_____

Location of the problem:
Bladder Urine Prostate Kidney
Other _____
_____

How long does the problem last?
30 minutes 1 hour It is always there
Other _____

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

Is the problem constant or variable?
Dull then Sharp Very sharp then leaves Always there
Other _____

When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other _____

Does the problem interfere with your normal functions?
Yes No
If yes, please explain:
_____
_____
_____

Does anything improve your condition or make it Worse? _____
_____
_____

Name _____ Date of Birth: _____Date:_____
(Last) (First) (MI)

Personal history of: CIRCLE

Cancer	Y	N
High Blood Pressure	Y	N
Diabetes	Y	N
Lung Disease	Y	N
High Cholesterol	Y	N
Heart Disease	Y	N
Thyroid Disease	Y	N
TB Exposure	Y	N
MRSA	Y	N

List ALL surgeries with dates: None

_____
_____
_____
_____
_____
_____

Defibrillator or Pacemaker: Y N
Date: _____
Other Implanted Devices: Y N
_____

Colonoscopy: Y N
Date:_____
Influenza (Flu) Vaccine Y N
Date:_____

Serious illnesses in immediate family:

	Mother	Father	Sibling
Cancer	☐	☐	☐
High Blood Pressure	☐	☐	☐
Diabetes	☐	☐	☐
Lung Disease	☐	☐	☐
High Cholesterol	☐	☐	☐
Heart Disease	☐	☐	☐
Thyroid Disease	☐	☐	☐
Kidney Stones	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

Ob/Gyn History (female patients only):
Last Pap Smear:_____

Last mammogram: _____
Total # of pregnancies: _____
Total # of births: _____
Sexually active: Y N
Last menstrual period:_____

List any Medical Problems/Hospitalizations:

_____
_____
_____
_____
_____
_____
_____

Medications with dosage and frequency:(Include all over the counter medications, vitamins, and supplements)

_____
_____
_____
_____
_____
_____
_____

List all Allergies and Reactions:

_____
_____

_____
_____

Occupation: _____
Marital Status:
Single Significant Other Married Divorced Widow
Habits:
Smokeless tobacco Y N Amount per day _____
#years _____
Cigarettes Y N Amount per day _____
years _____
Cigars Y N Amount per day _____
years _____
Pipe Y N Amount per day _____
years _____
Quit: Year _____
How often do you drink alcohol? _____
Beer / Liquor / Wine Amount _____
Illicit Drug Use: _____
Coffee / Soda / Tea / Energy Drinks: # per day _____

Do you have Health Care Proxy Document: Y N
Appointed proxy name_____
Relationship _____

Name _____ Date of Birth: _____Date:_____
(Last) (First) (MI)

Review of Systems

Do you presently have any of the following problems? Circle **Y**es or **N**o.

Constitutional Symptoms
- Fever or chills Y N
- Weight loss Y N
- Other _____

Eyes
- Blurry vision Y N
- Double vision Y N
- Other _____

Cardiovascular
- Chest pain Y N
- Palpitations Y N
- Other _____

Respiratory
- Shortness of breath Y N
- Wheezing Y N
- CPAP/BIPAP Y N
- Oxygen Y N
- Other _____

Gastrointestinal
- Nausea/vomiting Y N
- Heartburn/indigestion Y N
- Constipation Y N
- Other _____

Genitourinary
- Blood in urine Y N
- Daytime urinary frequency Y N
- Nighttime urinary frequency Y N
- Erectile dysfunction Y N
- Kidney disorder Y N
- Sexually transmitted diseases Y N
- Urine leakage Y N
- Urine retention Y N
- Pads # per day ____ Y N
- Other _____

Musculoskeletal
- Joint Pain Y N
- Bone Pain Y N
- Other _____

Skin
- Itching Y N
- Rash Y N
- Other_____

Neurological
- Numbness Y N
- Tingling Y N
- Other _____

Psychological
- Depression Y N
- Anxiety Y N
- Mental Illness Y N
- Other _____

Hematologic/Lymphatic
- Blood Clotting Disorder Y N
- Bruising Y N
- Other _____ Y N

Ears, Nose, Throat
- Hearing Loss Y N
- Congestion Y N
- Tinnitus Y N
- Sore throat Y N
- Vertigo Y N
- Nosebleeds (epistaxis) Y N
- Sinus infections Y N
- Difficult swallowing Y N
- Other _____ Y N
- Weak stream Y N

PHYSICIAN USE ONLY: (Comments/Notes)

SIGNATURE OF PHYSICIAN _____