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 (___)_____________ Cell phone Carrier _________________

Work Phone (___)_________________ E-mail Address: ____

DOB: ____/____/____ Age: ___________ SS#: _________-_________-__________

(optional - Medicaid patients must fill out)

Sex: ☐Male ☐Female Sex at Birth: ☐Male ☐Female

Gender Identity: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐ Not sure/Questioning ☐ Neither exclusively Male or Female/Non-Binary

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

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:___________
COVID vaccine: 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 ____________________________