CONFIDENTIAL

James R. Fishman, M.D.

Central Arizona Urologists, Ltd.

www.AzUrology.com • (602) 242-1556

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/Name:_____Address_____City_____State_____Zip_____

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

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_____-_____-_____

Insurance Address:_____

SECONDARY: _____ ID#:_____ Group #:_____

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

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

Insurance Address:_____

Cancellation Policy: I understand when I make an appointment, the physician, provider and staff are scheduled for my care. There is a $50 fee if I miss my scheduled appointment or not cancel 24 hours in advance.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to James R. Fishman, M.D., 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 HIPAA 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 send emails ❑ OK to leave voicemails on Phone #

_____ _____ _____ _____

Signature of Patient **Date** Staff Initials Date

MEDICAL AND SURGICAL HISTORY

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

II. Past Medical and Surgical History

A. Surgeries

	Hospital	Surgeon	Year
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

B. Medical Illnesses

	Yes	No
1. Heart Disease	❑	❑
2. High Blood Pressure	❑	❑
3. Lung Disease (COPD)/ Asthma	❑	❑
4. Diabetes	❑	❑
5. Cancer	❑	❑
6. Kidney Disease/Stone	❑	❑
7. Gastrointestinal Disease (Ulcers, Diverticulitis, etc.)	❑	❑
8. Bleeding Problems	❑	❑
9. Sexually Transmitted Disease	❑	❑
10. HIV	❑	❑

	Yes	No
High Cholesterol	❑	❑
Hepatitis ❑ A / ❑ B / ❑ C	❑	❑
Seizure Disorder	❑	❑
Parkinson's / Alzheimer's	❑	❑
Glaucoma	❑	❑
Acid reflux (GERD)	❑	❑
Thyroid ❑ High / ❑ Low	❑	❑
Depression / Anxiety	❑	❑
Stroke	❑	❑
Other_____		

III. Medications (Including aspirin and vitamin/herbal)

❑ If Yes	Name	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

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

If Yes, to what

❑ If Yes	Name	Reaction
1.		
2.		
3.		
4.		
5.		
6.		

V. Family History

	Living	Deceased	Illnesses	Age & Cause of Death
Father	❑	❑	_____	_____
Mother	❑	❑	_____	_____
Sisters	#____❑	#____❑	_____	_____
Brothers	#____❑	#____❑	_____	_____

VI. Family History of the Following.

	Yes	No		Yes	No		Yes	No
1. Heart Disease	❑	❑	4. Cancer(s)	❑	❑	7. Bleeding Problems	❑	❑
2. Kidney Disease	❑	❑	5. Hepatitis	❑	❑	8. Other:_____	❑	❑
3. Prostate Disease	❑	❑	6. Gastrointestinal Problems	❑	❑			

VII. Social Habits

	Yes	No
1. Do/did you smoke?	❑	❑
2. Do you drink alcohol?	❑	❑
3. Any drugs (illicit)?	❑	❑
4. Any caffeine use?	❑	❑
Coffee	❑	❑
Tea	❑	❑
Sodas	❑	❑
5. Any blood transfusions?	❑	❑

Amount (packs/day)_____ How many years?_____When did you quit?_____

VIII. Do you have any of these symptoms?

	Yes	No
1. Constit.		
Fever	❑	❑
Wt. Loss	❑	❑
Loss of Appetite	❑	❑
2. Eyes		
Vision Blurring	❑	❑
Double Vision	❑	❑
3. ENT.		
Trouble Swallowing	❑	❑
Ringing in Ears	❑	❑
4. Cardiovascular		
Chest Pain	❑	❑
Shortness of Breath	❑	❑
Palpitation	❑	❑
Swelling of Legs	❑	❑

	Yes	No
5. Resp.		
Cough	❑	❑
Cough up blood	❑	❑
Breathing difficulty	❑	❑
6. GI.		
Nausea	❑	❑
Vomiting	❑	❑
Belly Pain	❑	❑
Diarrhea	❑	❑
Blood Stool	❑	❑
7. Musculo-skeletal		
Arthritis	❑	❑
Muscle weakness	❑	❑
8. Integumentary		
Skin rases	❑	❑

	Yes	No
9. Neurological		
Strokes	❑	❑
10. Psychiatric		
Memory Loss	❑	❑
Change in Personality	❑	❑
11. Endocrine		
Intolerance to Heat	❑	❑
Intolerance to Cold	❑	❑
Constant Thirst	❑	❑
12. Hematologic/Lymphatic		
Lymph Node Swelling	❑	❑
Bruise Easily	❑	❑

IX. What is your Weight_____ **Height**_____