PATIENT INFORMATION

(Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ____________ (First) ________ (MI) ____ Previous Name ____________

Address Line 1 ____________________

City, State ____________ ZIP ________

Home Phone ________ Cell No. ________ Work Phone ________ Ext. ______

Primary Care Provider (PCP) ____________ Referring Provider ____________

Rendering Provider Name (this practice) ____________ E-Mail Address: ____________

Date of Birth MM ____ /DD ____ /YYYY ______ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ ________

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name ____________

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name ____________ First Name ____________

Phone Number ____________ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ____________ ☐ Guardian

Address Line 1 ____________________

City, State ____________ ZIP ________

Home Phone ________ Work Phone ________ Ext. ______

Referring Provider Name ____________________

RESPONSIBLE PARTY INFORMATION

(information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ____________ (First) ____________ (MI) ______

Guarantor Account Number ____________ Date of Birth MM ____ /DD ____ /YYYY ______

Social Security Number _____-_____-_____ Telephone ____________

E -Mail Address ____________ Sex ☐ F – Female ☐ M - Male

Address Line 1 ____________________

City, State ____________ ZIP ________

Employer____________ Employer Phone Number____________

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____________ (_____)________

Name of Insured____________ Patient Relationship to Insured____________

Subscriber ID (Policy Number)________ Group ID________ Copay Amount________

Effective Date________ Termination Date________ Date of Birth MM ____ /DD ____ /YYYY ______

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number____________ (_____)________

Name of Insured____________ Patient Relationship to Insured____________

Subscriber ID (Policy Number)________ Group ID________ Copay Amount________

Effective Date________ Termination Date________ Date of Birth MM ____ /DD ____ /YYYY ______

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature ____________________ ***Date***________

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Rose Urology

PATIENT MEDICAL HISTORY

Name:______________________________ Date:______________

Date of Birth:____________ Age:_______ Family or Referring Doctor:______________

Pharmacy:______________________ Pharmacy #____________ Appointment Date:__________

HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT (What is the main reason for your visit today?)______________

____

____

Date of onset:____________ List location (left or right):______________

Any Test? What type?______________________________

____

Blood in Urine? Y / N
Color of Urine? Bright Red____, Pink____,
Dark Red____, Clear____, Microscopic____
Clots in Urine? Y / N
Frequent Urination Y / N
How Often? Every _____ hours
Nocturia? (Urinating at night) Y / N
How Often? ______ times a night

Slow or weak stream? Y / N
Burning with Urination? Y / N
Leaking of Urine? Y / N All the time? Y / N
With exercise____, With cough____
Pain with Intercourse? Y / N
Problems with Erections? Y / N
Have you had this problem before? Y / N
When?____________________

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

List all serious illnesses including hospitalizations:

☐ None ______________________

____

____

____

Have you ever been diagnosed with:
Circle yes (Y) or no (N)

Y | N	Urinary Tract Infections	Y | N	Cancer Type
Y | N	Prostate Problems	Y | N	Kidney Stones
Y | N	Heart Attack	Y | N	Venereal Disease
Y | N	Heart Disease	Y | N	Heart Murmur
Y | N	Stroke	Y | N	Vascular Disease
Y | N	Blood Clots	Y | N	Diabetes
Y | N	High Blood Pressure	Y | N	Epilepsy/Seizures
Y | N	Asthma	Y | N	Emphysema
Y | N	Pneumonia	Y | N	Ulcers

List all serious illnesses in your immediate family:

☐ None ______________________

Mother: Living___ Died___ Age___ Died of______

Father: Living___ Died___ Age___ Died of______

Occupation (Specify)______________________

Marital Status:______________ Years?________

How many children?______________________

Females: Are you pregnant? Y / N How many pregnancies?_

Vaginal____C-Section____Date of last menstrual period:_____

Do you smoke? Y / N Have you smoked in the past? Y / N

How much?____________ How long?__________

Do you drink alcohol? Y / N

How much? Beer________ Wine________ Liquor______

Coffee Y / N How much?__________

Tea Y / N How much?__________

Soda Y / N How much?__________ What kind?______

______________________ ______________________

______________________ ______________________

Current Medications (including over the counter and herbal medications):

____

____

____

____

List all surgeries and dates if possible:

____

____

____

____

Please add any additional information to assist in your care:

____

____

____

PATIENT CONSENT FOR SURESCRIPTS RELEASE OF MEDICATION HISTORY

What is Surescripts? Surescripts connects pharmacies, care providers, benefit managers, and operates a network to allow for the movement of electronic clinical health information between different health information systems. Through the Surescripts network, authorized prescribers and pharmacies can gain access to prescription information and related information for use in providing clinical care to patients. What is the Medication History? The Surescripts Medication History service allows prescribers and pharmacists to use the Surescripts network to access a patient's medication history across providers, at the point of care. This service can be used in the course of providing routine care, as well as during emergencies. In both cases, Medication History enables health care providers to make a more informed clinical decision. To provide this service, Surescripts connects to a patient's medication history data stored in the databases of community pharmacies and pharmacy benefit managers. Surescripts then presents that data to prescribers through software from a certified vendor.

I understand that Rose Urology and/or its affiliated entities has deployed an integrated electronic medical record. I acknowledge that by signing this form below I consent to and agree that Rose Urology providers and all other users of the integrated electronic medical record may request, access, and receive my medication history data from Surescripts. I understand that I can withdraw my consent for Rose Urology and its affiliated providers to access my medication history data from Surescripts by contacting the Rose Urology Privacy Officer and completing the Rose Urology Opt-out form. I understand that revoking this consent will not have any effect on actions taken prior to such revocation.

Patient Name Printed: ____ Date: ______________

Signature: ____

Witness: ____ Date: _________________

Acknowledgement of Notice of Privacy Practices

By signing this form, you acknowledge that you have received our "Notice of Privacy Practices" (the "Notice"). This Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this acknowledgment.

By signing this form, you further acknowledge that medical information collected at the Rose Urology, LLC will be stored in a medical record system compliant with such rules and kept securely in line with state and federal regulations.

______________________________ Signature or Patient or Legally Authorized Representative

____
Printed Name of Patient or Legally Authorized Representative

__________ Date

________________ Relationship to Patient

I authorize the following individuals to communicate with this medical practice on my behalf:

______________________________ ______________________________

Printed Name and Signature

If the patient refused or was unable to acknowledge the Notice of Privacy Practices, please explain why:

____
____
____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION THROUGH DRCONNECT

Cleveland Clinic DrConnect Operations 3175 Science Park
Beachwood, OH 44112

Phone: 877.224.7367 (877.CCHS.EMR)
Fax: 216.445.9668
Email: drconnect@ccf.org

Patient:

SSN:

Clinic #:

Date of Birth: / /

Address:

City: State: Zip:

Telephone:

I hereby authorize the Cleveland Clinic and its affiliates (collectively, "Cleveland Clinic") to release my health information as indicated below. **I understand and acknowledge that this release will include records of any treatment I have received for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results, diagnoses and treatment. This authorization does not include permission to release Psychotherapy Notes as defined below.* The release of Psychotherapy notes requires a separate authorization.**

Release To: Rose Urology

Telephone: 772-564-1799

Address: 49 Royal Palm Pointe Suite 100 Beach State: FL Zip:32960

Reason for disclosure: . Continuity of Care

Information to be disclosed: I understand and agree that my **complete and full medical record** will be released regardless of dates of treatment. The information released will include, but not be limited to, the following records:

•Alcohol and/or drug abuse treatment records •Mental health treatment records including treatment for mental illness •HIV tests, results, diagnosis and treatment •Discharge summaries • History & physical •Laboratory reports •Operative reports •Pathology reports •Medications •Clinic/Progress notes •Diagnoses

This authorization is subject to revocation at any time except to the extent the action has been taken thereon. I may revoke this authorization at any time by contacting Cleveland Clinic at the contact information listed above. I understand that the recipient of my health information may be charged for the service of releasing medical information.

This authorization will expire one hundred eighty-five (185) days from the date written below, unless I specify an earlier date: _. I understand that information released pursuant to this authorization may remain part of my permanent medical record at Recipient. My health care (or payment for care) will not be affected by whether or not I sign this authorization. Once my health information is released, redisclosure of my health information by the Recipient may no longer be protected by law

NOTICE TO RECIPIENT OF INFORMATION & ADDITIONAL PATIENT ACKNOWLEDGEMENT The information disclosed pursuant to this authorization will contain any and all information contained in my medical record that is protected by Federal confidentiality rules relating to treatment provided by Alcohol and Drug Abuse Program (42 C.F.R. Part 2) and state law pertaining to the disclosure of HIV/AIDS information. **These rules prohibit Recipient from making any further disclosure of this information** unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 relating to the disclosure of alcohol and drug abuse program information or state law pertaining to disclosure of HIV/AIDS information. A general authorization for the release of medical or other information is NOT sufficient for these purposes. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_______________ / _______________ ____ / ____ / ____

*Signature of Patient/Patient's Personal Representative** Printed Name Date Signed*

____

Relationship if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.*

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. cour appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.*