

Patient Information		Name (Last, First, MI)		Today's Date	
Street Address (if PO Box also give physical home address)			APT. #____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
City	State	Zip		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Social Security #	Daytime Phone ()	Evening Phone ()		Cell Phone ()	
Occupation:	Employer Name and Address:			If Student: <input type="checkbox"/> Full time <input type="checkbox"/> Part Time	

Insurance Information		* Please give your insurance card <u>and</u> drivers license or picture ID to the receptionist to be copied *			
Name of Primary Insurance Company		Policy #		Group #	
Please indicate the policyholder for the primary insurance: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____					
Name of Secondary Insurance Company		Policy #		Group #	
Please indicate the policyholder for the secondary insurance: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____					

Spouse's information or Parent's information (if Patient is covered by parent's Insurance)	Emergency Contact	Referral Info How did you hear about us?	
Spouse's or Parents Name In case of an emergency, we may contact this person: <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Please list the nearest living relative or friend not living in your household</i> In case of an emergency, we may contact: Name _____ Daytime Phone () _____ Evening Phone () _____ Relationship to Patient _____	<input type="checkbox"/> From a Current/Prior Patient Name _____ <input type="checkbox"/> Internet <input type="checkbox"/> Practice web site- www.vasectomyNJ.com <input type="checkbox"/> www.vasectomy.com <input type="checkbox"/> Search engine <input type="checkbox"/> Goggle <input type="checkbox"/> Yahoo <input type="checkbox"/> MSN/Bing <input type="checkbox"/> Other Web avenue _____ <input type="checkbox"/> Newspaper Which one? _____ <input type="checkbox"/> From a physician Name _____ Town _____ <input type="checkbox"/> Yellow pages <input type="checkbox"/> Referred by health plan/insurance directory	
Spouse's or Parent's Date of Birth (Required if covered by their insurance)	Spouse's or Parents Employer (Required if covered by their insurance)	Your Primary Care Physician is: NAME _____ Town _____	

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION and ACKNOWLEDGMENT of RECEIPT OF NOTICE OF PRIVACY PRACTICES and FINANCIAL/ CANCELLATION POLICY	<i>Please read the following and sign below:</i>
<p>Assignment of Benefits and Release of Information: By signing below, I hereby assign all insurance benefits to which I am entitled including Medicare and/or any other insurance or health plans to Jeffrey I. Silverstein, M.D. and/or AUA, PC. I authorize Dr. Silverstein and/or AUA, PC to release to the Health Care Financing Administration, its agents or to other insurance company any information that is in the record and is necessary to secure payment.</p> <p>Notice of Privacy Practices Acknowledgment By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.</p> <p>Financial and Cancellation Policy Acknowledgment I understand that by signing below, I agree to abide to the financial and cancellation policy described herein. I am financially responsible for all charges including any copay, deductible, non-covered service, or any charges not paid by the insurance company. I understand that if my insurance requires a referral or precertification and I do not have same, I will be responsible for the charges. Co-payments, deductibles, non-covered services, and past due balances are due at the time of service. I understand that it is my responsibility to inform this office if there is a change in my health insurance. Payment in full will be due at the time of service if I do not have insurance, if this office does not participate in my plan, or if the services are not covered under my plan. Cancellation policy: Office Visit: The office requires at least 24 hours notice when canceling an office visit appointment. Failure to provide this notice will result in a \$ 75.00 charge. In- office Procedure: A \$150.00 fee will be charged if I cancel a procedure with less than 48 hours notice. Returned Check Fee \$40.00. Overdue accounts: Outstanding balances are due upon receipt of statement. An interest charge of 1.5% per month will be added to unpaid patient balances. I understand that if account goes to collections for non-payment I will be responsible for all court and legal fees. Additionally, if I had an in-network discount applied to fees and I breach my responsibility to pay balances due under the terms of my insurance agreement, then as a result of that breach I will forfeit any and all such discounts and I will be responsible for the full fee of services rendered.</p>	
X _____	Date: _____
Signature of Patient or responsible Party	

ATLANTIC UROLOGY ASSOCIATES, P.C.
Center for No-Scalpel Vasectomy
JEFFREY I. SILVERSTEIN, M.D.
Diplomate American Board of Urology

PRINT YOUR NAME: _____ Today's date: _____

1. Describe current medical problem/reason for today's visit: _____

2. Describe all **MEDICAL PROBLEMS** you have had or are under treatment for:

Diabetes Mellitus	NO	YES	Cancer	NO	YES Specify: _____
High Blood Pressure	NO	YES	Arthritis	NO	YES
Stroke	NO	YES	Seizures	NO	YES
Lung disease	NO	YES Specify: _____	Hepatitis	NO	YES Specify: _____
Congestive Heart (CHF)	NO	YES	HIV/ AIDS	NO	YES
Angina/ Chest pain (ASHD)	NO	YES Specify: _____	other (please list)	_____	
Heart Attack (MI)	NO	YES WHEN? _____		_____	
Heart valve disease	NO	YES Specify: _____		_____	
Kidney disease	NO	YES Specify: _____		_____	
(male) Prostate disease	NO	YES Specify: _____		_____	

3. List other physicians currently treating you: _____

4. List any **SURGERY** you have had and date performed:

Operation	Date	Operation	Date
_____	_____	_____	_____

5. List all **MEDICATIONS** you take: (If you have list we would like to make copy. Copy on chart) _____

Do you take Aspirin regularly? YES NO

6. List all your known **ALLERGIES**: _____

Check If Applies: Are You Allergic To: Latex Shellfish X-Ray Dye

7. SOCIAL HISTORY:

Do You Smoke? NO YES How Much? _____ QUIT When? _____

Do You Drink Alcohol? NO YES How Much? _____

Have you ever used recreational (non-prescribed) drugs? NO YES What Type? _____

Are You: Married Single Widowed Divorced

Females: When was your last menstrual period? _____

Are you pregnant? YES NO

Are you planning a pregnancy? YES NO

Have you had a hysterectomy? YES NO or tubal ligation YES NO?

8. FAMILY HISTORY:

Check If Applies: Prostate Cancer High Blood Pressure Heart Disease Diabetes

9. Please provide us with your **Pharmacy** Name: _____ Town _____ Phone: _____

10. Please give details explaining **any additional information** that you feel may be important: _____

Atlantic Urology Associates, PC
Review of Systems Questionnaire

PATIENT NAME: _____

DATE: _____

Constitutional	Yes	No
Feeling tired		
Fever		
Chills		
Recent weight loss (lbs _____)		
Recent weight gain (lbs _____)		

Ear, Nose, Throat	Yes	No
Nasal congestion		
Post-nasal drip		
Sore throat		
Earache (right)		
Earache (left)		

Urinary	Yes	No
Pain during urination		
Increased frequency of urination		
Blood in urine		
Urinating more than 1 time at night		

GI	Yes	No
Decreased appetite		
Abdominal pain		
Nausea		
Vomiting		
Diarrhea		
Constipation		
Heartburn		
Blood in stool		

Skin / Musculoskeletal	Yes	No
Skin rash		
Neck pain		
Back pain		
Joint pain		

Chest	Yes	No
Difficulty swallowing		
Cough		
Shortness of breath		
Palpitations		
Chest pain or discomfort		

Hemo / Endocrine	Yes	No
Easy bruising tendency		
Excessive sweating		
Sweating heavily at night		
Excessive thirst		
Temperature intolerance		

Neuro / Eyes	Yes	No
Headache		
Dizziness		
Fainting or Vasovagal episodes		
Numbness		
Decrease in strength		
Ringin in the ears		
Sleep disturbances		
Depression		
Anxiety		

Male History (men only)	Yes	No	Gynecological (women only)	Yes	No
Difficulty with erections			Unexplained vaginal bleeding		
Discharge from penis			Vaginal discharge		
Hx of STD			Vaginal pain		
Hx of prostate infection			Vaginal itching or burning		

REVIEWED BY DR. _____