Matthew S. Lief, M.D., F.A.C.S., P.A.

Diplomate of American Board of Urology
Adult and Pediatric Urology

Referred by:_____ Date:_____

Name Last:_____ First:_____ Age:_____

Address:_____ City_____ State_____ Zip Code_____

Home Phone:( )_____ Work Phone:( )_____

SS#:_____ Marital S / M / D / W

Occupation:_____ Employer:_____ Date of Birth:_____

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

Type of Insurance:_____ None/Self Pay____

ID/Policy #:_____ Group#:_____ Customer Service Ph #:_____

Secondary Insurance:_____ ID/Policy #:_____ Group#:_____

(We do not accept credit cards)

Insurance Payment Verification

I authorize the assignment of medical benefits be payable to Matthew S. Lief, M.D., F.A.C.S., P.A. I understand that I am responsible for payment of services rendered. I certify all information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of any requested information to medicare or any insurance representative, necessary to process medical claims.

LIFETIME INSURANCE SIGNATURE:_____

Medical History

Allergies:
Medications:_____ Reaction:_____

List Previous Surgeries:_____

PATIENT SIGNATURE:_____

9750 NW 33rd St., Suite 218, Coral Springs, Florida 33065 (954) 755-3801 (954) 755-5229
9980 Central Park Blvd., Suite 210, Boca Raton, Florida 33428 (561) 4479-2223
5800 Colonial Drive, Suite 108 Margate, Florida 33063 (954) 755-3801

Dr. Matthew S. Lief, M.D., P.A., F.A.C.S.

I,_____ GIVE PERMISSION TO DR. LIEF OR HIS STAFF TO LEAVE ANY RESULTS OF MY TESTS OR EXAM WITH: (PLEASE, CHECK ALL APPROPRIATE SPACES).

___ LEAVE MESSAGE ON ANSWERING MACHINE OR FAX AT HOME

___ LEAVE MESSAGE WITH SPOUSE, FAMILY MEMBER

___ LEAVE MESSAGE WITH _____ (NAME OF PERSON)

___ LEAVE MESSAGE ON ANSWERING MACHINE AT WORK

___ LEAVE MESSAGE WITH **ONLY MYSELF** BY PHONE OR FAX _____ INITIALS

I,_____GIVE PERMISSION FOR MY MEDICAL RECORDS TO BE FAXED OR MAILED UPON REQUEST TO: (PLEASE, CHECK ALL APPROPRIATE SPACES).

____ MY PRIMARY CARE PHYSICIAN

____ MY GYNECOLOGIST

____ ANY OTHER PHYSICIAN OR FACILITY THAT WILL BE OR IS INVOLVED IN MY CARE

____ DR. MATTHEW LIEF

____ MY INSURANCE CARRIER _____ INITIALS

I,_____GIVE PERMISSION FOR DR. LIEF OR HIS STAFF TO DISCUSS ANY MEDICAL CONDITION WITH: (PLEASE, CHECK ALL APPROPIATE SPACES).

____ MY SPOUSE

____ MY CHILDREN

____ MY PARENTS

____ OTHERS,_____ _____ INITIALS

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS NECESSARY FOR DR. LIEF TO RENDER MEDICAL SERVICES BY SIGNING LIFETIME SIGNATURE BELOW.

PRIOR TO SIGNING THIS DOCUMENT, I HAVE READ, REVIEWED, BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT, AND UNDERSTAND DR. LIEF CURRENTLY EFFECTIVE NOTICE OF PRIVACY PRACTICES, AND DO HEREBY AGREE TO ITS TERMS.

_____ _____

SIGNATURE TODAY'S DATE

DR. MATTHEW S. LIEF, M.D.
9750 NW 33RD STREET SUITE 218
CORAL SPRINGS, FLA 33065
OFFICE NO. 954-755-3801 FAX NO. 954-755-5229

Matthew S. Lief, M.D., F.A.C.S., P.A.

Diplomate of American Board of Urology

Lifetime Authorization Signatures

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. **TREATMENT AUTHORIZATION-** I, hereby give Dr. MATTHEW LIEF consent for medical treatment.

II. **RELEASE OF INFORMATION-** I the below named patient, do hereby authorize any physician of this group examining and/or treating me to release to any third party payor (such as an insurance company or governmental agency, example: Blue Shield of _____ or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

III. **PHYSICIAN INSURANCE ASSIGNMENT-** I, the belowed named subscriber, hereby authorize payment directly to any physician of this group examining or treating me any surgical and/or medical benefits herein specified and otherwise payable to me for their services as discribed but not exceed the reasonable and customary charge for these services.

IV. **MEDICARE / MEDICAID- Patient's certification authorization to release information and payment request.** I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/ Division of Family Services or its intermediaries or carriers any information needed for this or related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to physician treating me.

V. **I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN"S OFFICE.** This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by insurance or third payer within a reasonable period of time not exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

DATE: _____ **PATIENT:** _____

Matthew S. Lief, M.D., P.A., F.A.C.S.
Diplomat of American Broad of Urology
Adult and Pediatric Urology

Medication Update

Please list the current medications that you are taking at this time so that we may update your file.

Patient 's name:_____

Pharmacy Phone number:_____

	Medication	Strength (mg.)	Dosage (# times a day)	Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

9750 NW 33 rd Street Suite # 218, Coral Springs, FL 33065 (954) 755-3801 Fax (954) 755-5229
9980 Central park Blvd., Suite # 210, Boca Raton, FL 33428 (561) 479-2223
5800 Colonial Drive, Suite #303, Margate, FL. 33068 (954) 755-3801

Matthew S. Lief, M.D., F.A.C.S., P.A.

Diplomate of American Board of Urology

PATIENT NAME _____ DATE _____

Medical History

- ❑ Ringing In Ear _____
- ❑ Ear Infections - *Frequent* _____
- ❑ Dizziness/Fainting _____
- ❑ Hair Loss _____
- ❑ Failing Vision _____
- ❑ Eye Infections _____
- ❑ Nose Bleeds _____
- ❑ Sinus Trouble _____
- ❑ Sore Throats - *Frequent* _____
- ❑ Hayfever/Allergies _____
- ❑ Pneumonia _____
- ❑ Bronchitis/Chronic Cough _____
- ❑ Asthma/Wheezing _____
- ❑ Chest Pain _____
- ❑ Hair Loss _____
- ❑ High Blood Pressure _____
- ❑ Heart Murmur _____
- ❑ Swollen Ankles _____
- ❑ Leg Pain - *Walking* _____
- ❑ Varicose Veins/Phlebitis _____
- ❑ Loss of Appetite _____
- ❑ Difficulty Swallowing _____
- ❑ Indigestion or Heartburn _____
- ❑ Persistent Nausea/Vomiting _____
- ❑ Peptic Ulcers _____
- ❑ Abdominal Pain - *Chronic* _____
- ❑ Gall Bladder Trouble _____
- ❑ Jaundice/Hepatitis _____
- ❑ Change in Bowel Habits _____
- ❑ Diarrhea ❑ Constipation _____
- ❑ Diverticulosis ❑ Crohn's/Colitis _____
- ❑ Bloody or Tarry Stools _____
- ❑ Hemorrhoids _____
- ❑ Hernia _____
- ❑ Urine Infections - *Frequent* _____
- ❑ Blood In Urine _____

Urination-❑ Overnight > than twice
❑ Painful ❑ Loss of Control
❑ Decrease in Force/Flow

- ❑ Kidney Stones _____
- ❑ Venereal Disease _____
- ❑ Urethral Discharge _____
- ❑ Chronic Fatigue _____
- ❑ Weight Loss - *Recent* _____
- ❑ Anemia ❑ Bruise Easily _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Thyroid Disease _____
- ❑ Convulsions/Seizures _____
- ❑ Stroke _____
- ❑ Tremor/Hands Shaking _____
- ❑ Muscle Weakness _____
- ❑ Numbness/Tingling Sensations _____
- ❑ Headaches - *Frequent* _____
- ❑ Arthritis/Rheumatism _____
- ❑ Osteoporosis _____
- ❑ Back Pain - *Recurrent* _____
- ❑ Bone Fracture/Joint Injury _____
- ❑ Gout _____
- ❑ Foot Pain ❑ Cold Numb Feet _____
- ❑ Rashes ❑ Hives _____
- ❑ Psoriasis ❑ Eczema _____
- ❑ Nervousness ❑ Depression _____
- ❑ Memory Loss _____
- ❑ Moodiness - *Excessive* _____
- ❑ Phobias _____
- ❑ Mental Illness _____
- ❑ Lactose Intolerance _____
- ❑ Prostate Disease _____
- ❑ Sexual/Menstrual Dysfunction _____
- ❑ Frequent Infections _____
- ❑ Diphtheria _____
- ❑ Tetanus _____
- ❑ Chicken Pox ❑ Polio ❑ Mumps ❑ Measles ❑ Rubella ❑ Rheumatic Fever
- ❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
- ❑ Other _____
- ❑ Other _____

Females - *Please Complete*

Pregnant? ❑ Yes ❑ No
Planning Pregnancy? ❑ Yes ❑ No
Menstrual Flow:
❑ Regular ❑ Irregular ❑ Pain/Cramps
____Days of Flow ____Length of Cycle
Date-1st day of last period _____
❑ Pain/Bleeding during or after sex
Number of:
____Pregnancies ____Abortions
____Miscarriages ____Live Births
Birth Control Method _____
B.C. Pill (Name) _____
❑ Flushing/Menopause
Date of Last PAP Test _____
❑ Normal ❑ Abnormal
Date of Last Mammogram _____
Normal ❑ Abnormal

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Hair Loss	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High Blood Pressure	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Migraine	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Other _____						

Habits

- ❑ Alcohol: Type _____
  Amount _____
- ❑ Diet: Salt Intake _____
  Fat Intake _____
  Other _____
- ❑ Sleep: Difficulty Falling Asleep _____
  Continuity Disturbances _____
  Early Morning Awakening _____
  Daytime Drowsiness _____
  Other _____
- ❑ Smoke: Packs Daily _____
  How Long _____
  Interested in Stopping? _____
- ❑ Exercise Routine: _____
- ❑ Coffee: Cups Daily _____
  Other Caffeine _____

9750 N.W. 33rd Street, Suite 218 • Coral Springs, Florida 33065 • (954) 755-3801 • Fax (954) 755-5229
9980 Central Park Blvd. N., Suite 210 • Boca Raton, Florida 33428 • (561) 479-2223
5800 Colonial Drive, Suite 303 • Margate, Florida 33063 • (954) 755-3801