ATLANTIC UROLOGY ASSOCIATES, PC CENTER FOR NO-SCALPEL VASECTOMY ™

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

Insurance Information	* Please give your insurance card ***and*** 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: □Self □Spouse □Parent □Other _____		
Name of Secondary Insurance Company	Policy #	Group #
Please indicate the policyholder for the secondary insurance: □Self □Spouse □Parent □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: □ Yes □ No	*Please list the nearest living relative or friend **not** living in your household* In case of an emergency, we may contact: Name_____ Daytime Phone ( ) _____ Evening Phone ( ) _____ Relationship to Patient _____	□ From a Current/Prior Patient Name_____ □ Internet □ Practice web site- www.vasectomynj.com □ www.Vasectomy.Com □ Goggle search □ Other Web avenue _____ □ Newspaper Which one? _____ □ From a physician Name_____ Town_____ □ Yellow pages □ 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

Please read the following and sign below:

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.

Notice of Privacy Practices Acknowledgment By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

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 breech my responsibility to pay balances due under the terms of my insurance agreement, then as a result of that breech I will forfeit any and all such discounts and I will be responsible for the full fee of services rendered.

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	NO	YES Specify: _____	other (please list)			_____
Heart valve disease	NO	YES Specify: _____				_____
Heart Attack (MI)	NO	YES WHEN? _____				_____
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?_____ QUITWhen?_____
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:_____
_____
_____
_____ REVIEWED BY DR._____

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)		

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		
Ringing in the ears		
Numbness		
Decrease in strength		
Red eyes		
Sleep disturbances		
Depression		
Anxiety		

Male History (men only)	Yes	No
Difficulty with erections		
Discharge from penis		
Hx of STD		
Hx of prostate infection		

Gynecological (women only)	Yes	No
Unexplained vaginal bleeding		
Vaginal discharge		
Vaginal pain		
Vaginal itching or burning		

REVIEWED BY DR. _____