PLEASE PRINT ALL PAGES OF THIS DOCUMENT AND FOLLOW YOUR DOCTOR'S OFFICE INSTRUCTIONS.

Please complete these forms.
Reading information and instructions at home
before your visit can benefit you during your office appointment.

If you have questions, please call your doctor's office.

Forms and information provided here are the property of, and
are supplied by, this practice for your convenience
as a service of vasectomy.com.

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ATLANTIC UROLOGY ASSOCIATES, P.C.

JEFFREY I. SILVERSTEIN, M.D.

PATIENT INFORMATION SHEET

PATIENT LAST NAME	FIRST	M.I.	SEX ☐ Male ☐ Female	ACCOUNT NO.

ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH	HOME PHONE	WORK PHONE	REFERRING SOURCE
	( )	( )	

MARITAL STATUS: ☐ Single ☐ Married ☐ Other	WORK STATUS: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ None	SOC. SEC. NO.	DRIVER'S LICENSE

NEAREST RELATIVE NOT LIVING IN HOUSEHOLD	RELATIONSHIP	PHONE
		( )

ADDRESS	CITY	STATE	ZIP

PRIMARY INSURANCE

COMPANY NAME	POLICY NO.	GROUP NO.

ADDRESS	CITY	STATE	ZIP

RELATIONSHIP ☐ Self ☐ Spouse ☐ Child ☐ Other:

SECONDARY INSURANCE

COMPANY NAME	POLICY NO.	GROUP NO.

ADDRESS	CITY	STATE	ZIP

RELATIONSHIP ☐ Self ☐ Spouse ☐ Child ☐ Other:

EMPLOYMENT

COMPANY NAME	LENGTH - TIME EMPLOYED

ADDRESS	CITY	STATE	ZIP

☐ Check if Worker's Comp Related Injury	SUPERVISOR'S NAME

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

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 understand that 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 and I do not have one, I will be responsible for the charges. I authorize Dr. Silverstein and/or AUA, PC to release to the Health Care Financing Administration and its agents or the insurance company any information which is in the record and is necessary to secure payment.

X____ Date:__________

Signature of Patient or responsible party

RECEIPT OF NOTICE OF PRIVACY PRACTICES, WRITTEN ACKNOWLEDGMENT FORM

I have received the notice of privacy practices for Atlantic Urology Associates, PC.

X____ Date:__________

Signature of Patient or responsible party

ATLANTIC UROLOGY ASSOCIATES, P.C.
JEFFREY I. SILVERSTEIN, M.D.
Diplomate American Board of Urology

PRINT PATIENT 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	NO	YES	Cancer	NO	YES
High Blood Pressure	NO	YES	Arthritis	NO	YES
Stroke	NO	YES	Convulsions	NO	YES
Lung Disease	NO	YES	Hepatitis	NO	YES
Heart Trouble	NO	YES Specify:__________	Other (please list)__________		
Heart Attack	NO	YES WHEN?__________	__________		

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:______________________
   Do you take Aspirin regularly? ☐YES ☐NO

6. List all your known **ALLERGIES**:______________________
   Check If Applies: Are You Allergic To: Shellfish ☐ X-Ray Dye☐

7. **SOCIAL HISTORY:**
   Do You Smoke? NO YES How Much?__________ QUIT When?______
   Do You Drink Alcohol? NO YES How Much?__________
   Do You now or have you ever used 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, P.C.
JEFFREY I. SILVERSTEIN, M.D.
Diplomate American Board of Urology

PRINT PATIENT NAME: ______________________________ Today's date:________

ANY PROBLEMS with the following:	Yes	No	**If yes**, can you describe?
General Health			
Eyes, Glaucoma			
Hearing, Smell, Throat			
Heart, Blood pressure, Blood vessels			
Breathing, Lungs			
Digestion, Intestines			
Kidneys, Bladder, Prostate			
OB/GYN			
Muscles, Joints, Bones			
Skin, Breasts			
Headache, Seizure, Stroke			
Psychiatric			
Glands, Hormones, Thyroid			
Blood, Anemia			
Immune system, Allergies			

REVIEWED BY DR.__________