.

SETH P. LEVINE, M.D., F.A.C.S ABRAHAM KNOLL, M.D.

ASSOCIATES IN UROLOGY NORTH JERSEY, P.A.

Diplomates American Board of Urology

DATE_________________ PATIENT DATA FORM

LAST NAME________________________FIRST NAME_________________________MI_____

BIRTHDATE__________________ AGE______ M / F SOC.SEC. # __________________

ADDRESS__________________________CITY____________STATE____________ZIP______

TELEPHONE: HOME______________________________WORK________________________

DO YOU RECEIVE ANTIBIOTICS PRIOR TO DENTAL TREATMENT FOR JOINT REPLACEMENT OR MITRAL VALVE PROLAPSE? YES__________ NO__________

REFERRING MD___________________________________OCCUPATION_________________________

MARITAL STATUS : SINGLE____ MARRIED___ WIDOWED___ DIVORCED___ SEPARATED____

SPOUSE'S NAME____NUMBER OF CHILDREN_____

EMERGENCY CONTACT___________________________________TELEPHONE __________________

PHARMACY____TELEPHONE __________________

PRIMARY CARE MD_______________________________________ TELEPHONE__________________

INSURANCE POLICY HOLDER_________________________DOB_________SOC.SEC.# ____________

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, INCLUDING MAJOR MEDICAL, MEDICARE, BLUE SHIELD, HMO AND COMMERCIAL INSURANCE TO ASSOCIATES IN UROLOGY NO. JERSEY, PA. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL NON-COVERED CHARGES FOR PARTICIPATING INSURANCES AND ALL CHARGES FOR NON-PARTICIPATING INSURANCES. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO SECURE PAYMENT ON MY BEHALF. I AM AWARE THAT I AM RESPONSIBLE TO NOTIFY THIS OFFICE OF ANY CHANGE IN MY INSURANCE CARRIER (S), COVERAGE OR CO-PAY.

DO YOU HAVE A DRUG (P.A.A.D.) CARE? Y N DO YOU HAVE A PRESCRIPTION PLAN? Y N

DATE_____________________SIGNATURE____

I _______________________________ (HIC#________________________), REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ASSOCIATES IN UROLOGY NORTH JERSEY, P.A. FOR ANY SERVICES FURNISHED ME BY PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) AND ITS AGENTS ANY BENEFITS PAYABLE FOR RELATED SERVICES.

DATE_________________SIGNATURE____

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF ASSOCIATES IN UROLOGY NO. JERSEY, P.A.'S NOTICE OF PRIVACY PROTECTION.

DATE_________________SIGNATURE____

ASSOCIATES IN UROLOGY NORTH JERSEY, PA

NAME____**SS#**__________________**DATE**____________

REASON FOR VISIT:____

____

____

____

____

____

MEDICAL CONDITIONS (PLEASE LIST): ____

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HOSPITALIZATIONS YES____NO____ IF YES WHEN, WHERE AND FOR WHAT CONDITION

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____

SURGICAL PROCEDURES (PLEASE LIST) WHEN PHYSICIAN WHERE TREATED

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____

____

MEDICATIONS (INCLUDE OVER THECOUNTER)____

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____

____

ALLERGIES____

____

SMOKE____HOW MUCH_______QUIT WHEN________ ALCOHOL____HOW MUCH______QUIT WHEN_____________

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING:

CANCER_______DIABETES_______HEART DISEASE______HIGH BLOOD PRESSURE_______KIDNEY DISEASE________

INDICATE THE HEALTH STATUS OF FAMILY, IF DECEASED GIVE AGE AND CAUSE OF THE DEATH:

MOTHER____

FATHER____

BROTHERS____

SISTERS____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

NAME ______________________ SS# ______________________ DATE ______________

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following?

PLEASE ANSWER ALL QUESTIONS BY Circling Yes or No

Constitutional Symptoms

Weight change	Y	N
Loss of Appetite	Y	N

Other ______________________

Eyes

Blurred vision	Y	N
Double vision	Y	N
Difficulty seeing	Y	N
Glaucoma	Y	N

Other ______________________

Ear/Nose/Throat/

Ear infection	Y	N
Sore throat	Y	N
Difficulty hearing	Y	N
Wear a hearing aid	Y	N

Other ______________________

Cardiovascular

Palpitations	Y	N
Chest pain	Y	N
Abnormal cholesterol	Y	N
High blood pressure	Y	N
History of heart attack	Y	N

Other ______________________

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Emphysema	Y	N

Other ______________________

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Change in bowel habits	Y	N
History of colon cancer	Y	N

Other ______________________

Gynecologic

Abnormal vaginal bleeding	Y	N
Abnormal discharge	Y	N
Irregular periods	Y	N
Menopause	Y	N
History of breast cancer	Y	N

Last menstrual period ______________

Other ______________________

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Arthritis	Y	N

Other ______________________

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other ______________________

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Thyroid problem	Y	N

Other ______________________

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problems	Y	N

Other ______________________

Neurologic

Stroke TIA	Y	N
Tremors	Y	N
Dizzy spells	Y	N
Numbness or tingling	Y	N
Frequent headaches	Y	N

Other ______________________

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Allergic to shellfish	Y	N
Take antibiotics prior to dental procedures	Y	N

Other ______________________

Other ______________________

#Answers	Level of Service
0-1	1 or 2
2-9	3
10+	4 or 5