



The Center for Men's and Women's Urology

Shammai Rockove, M.D. F.A.C.S.

Completing all forms in their entirety and faxing, mailing or dropping them off will decrease your wait time at our office for your appointment.
New patient appointments that are missed without notice will not be rescheduled.

Personal Information:

Patient Name:		
Social Security#:	D.O.B.:	Sex:
Preferred Language*:	Race*:	Ethnicity*:
Emerg. Contact:		Phone#:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____		
Spouses Name:		Consent to speak with spouse? <input type="checkbox"/> Y <input type="checkbox"/> N

Preferred Pharmacy:

Name:	Intersection or Street Address and City:
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Mailing Address:

Second Address:

Street:	Street:
City, State, Zip:	City, State, Zip:
E-mail Address:	

Insurance Information:

Primary Insurance:	Secondary Insurance:
I.D. #:	I.D. #:
Group #:	Group #:
Ins. Address:	Ins. Address:
Insured's Name and DOB (if not self)	Insured's Name and DOB (if not self)

I wish to be contacted in the following manner (please indicate all that apply):

Home Phone #:	Ok to leave detailed message? Yes or No
Mobile Phone #:	Ok to leave detailed message? Yes or No
Consent to text mobile phone? <input type="checkbox"/> Y <input type="checkbox"/> N	Preferred contact: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Email
CFMWU has my permission to share my medical information with (name and relation):	

Primary Care Physician:	Referred By:
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Signature of Patient

Date

*The Federal Government requires The Center for Men's and Women's Urology to gather certain demographic information
Please be prepared to leave a urine specimen at every appointment.



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Patient Name: _____

Please initial each " _____ "

_____ **ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I request that payment of authorized benefits (Medicare, managed HMOs/IPAs and/or insurance companies) be made either to me or on my behalf to The Center for Men's and Women's Urology for any services furnished to me by my provider. I authorized any holder of medical information about me to release it to the following when applicable to determine benefits for related services:

- Division of Family Services
- Centers for Medicare and Medicaid Services
- Insurers and/or agents of these companies
- Responsible person(s) listed
- Other healthcare providers assisting in my medical care

_____ **CONSENT TO TREATMENT**

I hereby authorize The Center for Men's and Women's Urology and/or any physician or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

_____ **FINANCIAL AGREEMENT**

I understand unless other arrangements have been made in advance by either me or my health coverage carrier, payment in full is due at the time of service. Acceptable methods of payment are cash, personal checks, VISA, MasterCard, Discover Card, AMEX or Care Credit.

The Center for Men's and Women's Urology is contracted with many health plans. We will submit a claim to those plans for which we are contracted with and will require you to pay the authorized co-payment, deductible, and/or co-insurance at the time of service. It is our office policy to collect any unmet deductible and/or coinsurance at check-in. Every attempt will be made to notify you in advance as to the amount that will be collected.

If you have any questions or concerns regarding your coverage for procedures, screenings services, medications or particular conditions, you are responsible for obtaining this information prior to your appointment from your health plan. You agree to pay in full for all services considered "non-covered" services per your insurance policy if you choose to have the service provided.

If your insurance company does not pay for the services provided, or you do not have insurance, you agree to pay all charges of The Center for Men's and Women's Urology. Each bill is due and payable upon presentation or mailing of a statement to you. Should the account become delinquent, you agree to pay all costs of collection applied by a collection agency. Any suit filed may be brought in the county where the services are rendered.

You have the right to receive a good faith estimate for total expected costs upon request.

_____ **PHYSICAL FORM COMPLETION**

I understand if I, or a person/entity on my behalf, request The Center for Men's and Women's Urology to complete a disability, FMLA paperwork, home health, or other physical form, the practice will assess me a \$25 fee for simple and \$40 for detailed paperwork. Please allow 48 hours to complete.

_____ **CANCELLATION POLICY**

I understand I will be assessed a \$50 fee for Office Visits, \$100 fee for in-office procedures and a \$200 fee for hospital surgeries by The Center for Men's and Women's Urology, per their Cancellation Policy, if I:

- Do not show up for my appointment
- Do not cancel my appointment with a minimum of 24-hour notice
- Do not cancel my surgery 3 business days in advance

_____ **RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT**

I have received a copy of, or viewed online at www.1URO.com, The Center for Men's and Women's Urology Notice of Privacy Practices

_____ **OTHER**

I understand that a \$25 fee will be charged for any NSF checks in addition to any bank fees

We reserve the right to terminate you as a patient due to non-compliance, transferring care to another urologist, missing surgical appointments and/or multiple missed appointments.

I understand and agree to all of the above:

Signature of Patient (For patients 17 years of age or younger, a parent or guardian MUST sign)

Date



The Center For Men's and Women's Urology

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Patient Name: _____ Date: _____ Date of Birth: _____

Chief Complaint (briefly describe your primary urological problem): _____

Have you seen a urologist before? Yes or No _____

Medical Problems:

1	2
3	4
5	6

Previous Surgeries with Dates:

1	2
3	4
5	6

Medications You Take and Reason:

1	2
3	4
5	6

*We can refill your vitamins and have them shipped to you. Let us know when you check in if you would like this service.

Allergies You Have:

1	2
3	4
5	6

Patient Social History. Please check those that apply to you and indicate quantity if applicable:

Caffeine Intake?	Recreational Drugs?	How often do you exercise?
Drink Alcohol?	Tobacco Use?: Y/N <input type="checkbox"/> Current <input type="checkbox"/> Previous How long?: _____ <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other: _____	

Marital Status: Single Married Divorced Widowed Other: _____

Employed?: Yes No Occupation: _____

Family History. Indicate who has/had (F=Father; M=Mother; B=Brother; S=Sister; GF=Grandfather; GM=Grandmother; A=Aunt; U=Uncle)

Is your father alive?: Y/N	Is your mother alive?: Y/N	Do you have children?: Y/N	How Many?
Heart Disease	Mental Illness	Cancer	Bleeding Disorder
Stroke	Epilepsy/Convulsions	Diabetes	Kidney Disease
Prostate Cancer	High Blood Pressure	Thyroid Disease	



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Patient Name: _____ Date: _____ Date of Birth: _____

Please check if you are currently experiencing or have had any symptoms in the last 30 days

Y N General

<input type="checkbox"/>	<input type="checkbox"/>	fevers
<input type="checkbox"/>	<input type="checkbox"/>	chills
<input type="checkbox"/>	<input type="checkbox"/>	sweats
<input type="checkbox"/>	<input type="checkbox"/>	weight loss
<input type="checkbox"/>	<input type="checkbox"/>	weight gain
<input type="checkbox"/>	<input type="checkbox"/>	tiredness

Y N Eyes

<input type="checkbox"/>	<input type="checkbox"/>	blurring
<input type="checkbox"/>	<input type="checkbox"/>	double vision
<input type="checkbox"/>	<input type="checkbox"/>	irritation
<input type="checkbox"/>	<input type="checkbox"/>	discharge
<input type="checkbox"/>	<input type="checkbox"/>	vision loss
<input type="checkbox"/>	<input type="checkbox"/>	eye pain

Y N Ear/Nose/Throat

<input type="checkbox"/>	<input type="checkbox"/>	earache
<input type="checkbox"/>	<input type="checkbox"/>	ear discharge
<input type="checkbox"/>	<input type="checkbox"/>	decreased hearing
<input type="checkbox"/>	<input type="checkbox"/>	nasal congestion
<input type="checkbox"/>	<input type="checkbox"/>	nose bleeds
<input type="checkbox"/>	<input type="checkbox"/>	sore throat
<input type="checkbox"/>	<input type="checkbox"/>	hoarsness
<input type="checkbox"/>	<input type="checkbox"/>	nasal obstruction/discharge

Y N Cardiovasclar

<input type="checkbox"/>	<input type="checkbox"/>	chest pain
<input type="checkbox"/>	<input type="checkbox"/>	palpitations
<input type="checkbox"/>	<input type="checkbox"/>	swelling of lungs

Y N Heme/Lymphatic

<input type="checkbox"/>	<input type="checkbox"/>	abnormal bruising
<input type="checkbox"/>	<input type="checkbox"/>	bleeding
<input type="checkbox"/>	<input type="checkbox"/>	enlarged lymph nodes

Y N Respiratory

<input type="checkbox"/>	<input type="checkbox"/>	cough
<input type="checkbox"/>	<input type="checkbox"/>	shortnes of breath
<input type="checkbox"/>	<input type="checkbox"/>	wheezing

Y N Gastrointestinal

<input type="checkbox"/>	<input type="checkbox"/>	nausea
<input type="checkbox"/>	<input type="checkbox"/>	vomiting
<input type="checkbox"/>	<input type="checkbox"/>	diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	constipation
<input type="checkbox"/>	<input type="checkbox"/>	change in bowel habits
<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain

Y N Genitourinary

<input type="checkbox"/>	<input type="checkbox"/>	pain with urination
<input type="checkbox"/>	<input type="checkbox"/>	blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	discharge
<input type="checkbox"/>	<input type="checkbox"/>	urinary frequency
<input type="checkbox"/>	<input type="checkbox"/>	urinary hesitancy
<input type="checkbox"/>	<input type="checkbox"/>	urine leakage
<input type="checkbox"/>	<input type="checkbox"/>	urinary urgency
<input type="checkbox"/>	<input type="checkbox"/>	slowing urinary stream
<input type="checkbox"/>	<input type="checkbox"/>	genital sores
<input type="checkbox"/>	<input type="checkbox"/>	impotence
<input type="checkbox"/>	<input type="checkbox"/>	decreased libido
<input type="checkbox"/>	<input type="checkbox"/>	erection difficulty

Y N Skin

<input type="checkbox"/>	<input type="checkbox"/>	rash
<input type="checkbox"/>	<input type="checkbox"/>	itching
<input type="checkbox"/>	<input type="checkbox"/>	dryness
<input type="checkbox"/>	<input type="checkbox"/>	lumps
<input type="checkbox"/>	<input type="checkbox"/>	sores

Y N Allergic/Immunologic

<input type="checkbox"/>	<input type="checkbox"/>	hives
<input type="checkbox"/>	<input type="checkbox"/>	persistent infections

Y N Musculoskeletal

<input type="checkbox"/>	<input type="checkbox"/>	back pain
<input type="checkbox"/>	<input type="checkbox"/>	joint pain
<input type="checkbox"/>	<input type="checkbox"/>	joint swelling
<input type="checkbox"/>	<input type="checkbox"/>	muscle cramps
<input type="checkbox"/>	<input type="checkbox"/>	muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	joint stiffness

Y N Psychiatric

<input type="checkbox"/>	<input type="checkbox"/>	depression
<input type="checkbox"/>	<input type="checkbox"/>	anxiety
<input type="checkbox"/>	<input type="checkbox"/>	memory loss
<input type="checkbox"/>	<input type="checkbox"/>	suicidal ideation
<input type="checkbox"/>	<input type="checkbox"/>	hallucinations
<input type="checkbox"/>	<input type="checkbox"/>	difficulty sleeping

Y N Neurologic

<input type="checkbox"/>	<input type="checkbox"/>	weakness
<input type="checkbox"/>	<input type="checkbox"/>	seizures
<input type="checkbox"/>	<input type="checkbox"/>	fainting
<input type="checkbox"/>	<input type="checkbox"/>	tremors
<input type="checkbox"/>	<input type="checkbox"/>	lightheadedness
<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	headaches

Y N Endocrine

<input type="checkbox"/>	<input type="checkbox"/>	cold intolerance
<input type="checkbox"/>	<input type="checkbox"/>	heat intolerance
<input type="checkbox"/>	<input type="checkbox"/>	excessive thirst
<input type="checkbox"/>	<input type="checkbox"/>	weight change