DAVID SCHWARTZWALD, M.D., F.A.C.S.

GENERAL AND SURGICAL UROLOGY

URINARY INCONTINENCE SEXUAL DYSFUNCTION

PATIENT INFORMATION FORM ~ PLEASE PRINT CLEARLY

PATIENT NAME		TODAY'S DATE
LOCAL ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	BUSINESS PHONE
OUT OF TOWN ADDRESS		
CITY, STATE, ZIP CODE		OUT OF TOWN PHONE NUMBER
EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE NUMBER
PATIENT'S DATE OF BIRTH	AGE	PATIENT'S SOCIAL SECURITY NUMBER
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED		SPOUSE'S NAME
OCCUPATION	EMPLOYER	EMPLOYER PHONE NUMBER
REFERRED BY	PRIMARY CARE DOCTOR	DOCTOR'S PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE ☐ MEDICARE ☐ OTHER:	POLICY NUMBER / GROUP NUMBER
INSURED PARTY ☐ SELF ☐ SPOUSE ☐ OTHER:	SOCIAL SECURITY NUMBER OF INSURED PARTY
SECONDARY INSURANCE	POLICY NUMBER/GROUP NUMBER
INSURED PARTY ☐ SELF ☐ SPOUSE ☐ OTHER:	SOCIAL SECURITY NUMBER OF INSURED PARTY

AUTHORIZATION AND ASSIGNMENT

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND ACCURATE. I HEREBY AUTHORIZE DAVID SCHWARTZWALD, M.D., TO RELEASE ANY INFORMATION ACQUIRED DURING MY EXAMINATION TO MY INSURANCE CAMPANIES. I FURTHER AUTHORIZE PAYMENT DIRECTLY TO DAVID SCHWARTZWALD, M.D. FOR SERVICES RENDERED. I UNDERSTAND AND ACCEPT THAT I AM FINANCIALLY RESPONSIBLE TO DAVID SCHWARTZWALD, M.D. FOR ALL INSURANCE DEDUCTIBLES AND ALL FEES NOT COVERED BY MY INSURANCE. IN THE EVENT THAT I HAVE NO INSURANCE OR MY INSURANCE IS REJECTED, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES INCURRED. IF MY INSURANCE REQUIRES A REFERRAL FROM MY PRIMARY CARE DOCTOR, I UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING THE REFERRAL AND I UNDERSTAND THAT DAVID SCHWARTZWALD, M.D. CANNOT SEE ME WITHOUTT IT. I FURTHER UNDERSTAND THAT I WILL BE HELD RESPONSIBLE FOR ALL FEES INCURRED IF THE REFERRAL IS NOT OBTAINED. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE AND THAT IF COLLECTION SERVICES ARE REQUIRED ON MY ACCOUNT. I WILL BE RESPONSIBLE FOR ALL FEES INCURRED.

PATIENT SIGNATURE	DATE

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PATIENT HISTORY FORM

Todays Date:_____ Date of Birth: _____ Age: _____ Primary Dr.: _____

Last Name: _____ First Name: _____ M.I. _____ ☐ Male ☐ Female

Chief Complaint

What is the main reason for your visit? _____

_____

When did you notice the problem? _____

_____

How long does the problem last? _____

_____

Where is the problem located? _____

_____

What makes it better or worse? _____

_____

How severe is the problem on a 0 to 10 scale? (Least Severe) 0 1 2 3 4 5 6 7 8 9 10 (Most Severe)

Does it interfere with normal functions? _____

Past Medical History and Social History

Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widow
Race	☐ Caucasian	☐ African American	☐ Hispanic	☐ Other _____
Education	☐ High School/GED	☐ College	☐ Graduate Degree	☐ Other _____

Occupation _____ ☐ Part-Time ☐ Full-Time

Use of Tobacco ☐ Yes ☐ No Former If yes, how many packs? Per Day _____ Per Week _____

Use of Alcohol ☐ Yes ☐ No Former If yes, how many drinks? Per Day _____ Per Week _____

Do you take antibiotics prior to dental work or other procedures? ☐ Yes ☐ No

If yes, Why? _____

Have you needed chemotherapy or radiation? ☐ Yes ☐ No

If yes, Why? _____

Are you taking any blood thinners? ☐ Yes ☐ No ☐ Aspirin ☐ Coumadin ☐ Other _____

List Any Surgeries/Including Dates:

List Any Medical Illness / Including Dates:

Family History

History of Prostate Cancer? ☐Yes ☐No If yes, Who?_____

Father ☐Alive ☐Deceased at Age _____ Medical Problems?_____

Mother ☐Alive ☐Deceased at Age _____ Medical Problems?_____

Siblings Medical Problems: _____

Children Medical Problems: _____

Remarks:

DAVID SCHWARTZWALD, M.D., F.A.C.S.

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Review of Systems

Who is your family physician?_____

If applicable, who is your cardiologist?_____

Do you now, or have you had problems related to the following:

General:
- Fever ☐ Yes ☐ No
- Chills ☐ Yes ☐ No
- Weight Loss ☐ Yes ☐ No
- Other: _____

Eyes:
- Vision Difficulties ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No
- Other: _____

Allergic:
- Penicillin ☐ Yes ☐ No
- Sulfa ☐ Yes ☐ No
- IV Contrast ☐ Yes ☐ No
- Other: _____

Neurological:
- Dizzy Spells ☐ Yes ☐ No
- Strokes (CVA) ☐ Yes ☐ No
- Tremors ☐ Yes ☐ No
- Other: _____

Endocrine:
- Diabetes ☐ Yes ☐ No
- Thyroid Disease ☐ Yes ☐ No
- Excess Thirst ☐ Yes ☐ No
- Heat / Cold Intolerance ☐ Yes ☐ No
- Other: _____

Gastrointestinal:
- Nausea / Vomiting ☐ Yes ☐ No
- Ulcers / Heartburn ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No
- Other: _____

Cardiovascular:
- Chest Pain / Angina ☐ Yes ☐ No
- Heart Attack ☐ Yes ☐ No
- High Blood Pressure ☐ Yes ☐ No
- Heart Murmur ☐ Yes ☐ No
- Other: _____

Integumentary:
- Skin Rash ☐ Yes ☐ No
- Persistent Itch ☐ Yes ☐ No
- Other: _____

Musculoskeletal:
- Arthritis ☐ Yes ☐ No
- Back Pain ☐ Yes ☐ No
- Other: _____

Ear/Nose/Throat:
- Dry Mouth ☐ Yes ☐ No
- Sinus Problem ☐ Yes ☐ No
- Other: _____

Respiratory:
- Emphysema (COPD) ☐ Yes ☐ No
- Shortness of Breath ☐ Yes ☐ No
- Wheezes ☐ Yes ☐ No
- Other: _____

Hematological/Lymphatic:
- Immune Disorder ☐ Yes ☐ No
- Blood Clotting Problem ☐ Yes ☐ No
- Other: _____

Urological/Renal:
- Erectile Dysfunction (men) ☐ Yes ☐ No
- Urinary Infections ☐ Yes ☐ No
- Kidney Disease/or Failure ☐ Yes ☐ No
- Kidney Stones ☐ Yes ☐ No
- Other: _____

Psychological:
- Depression ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Other: _____

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Master Medication List

Today's Date:_____

Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____

Do you have **ALLERGIES** to any medications and/or foods? ☐ Yes ☐ No If yes Please List:

_____

_____

Please List All Medications You Are Currently Taking:

Medication	Daily Dose And Frequency	Reason

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

THIS SUMMARY IS PROVIDED TO ASSIST YOU IN UNDERSTANDING THE ATTACHED "NOTICE OF PRIVACY PRACTICES".

THE ATTACHED NOTICE OF PRIVACY PRACTICES CONTAINS A DETAILED DESCRIPTION OF HOW OUR OFFICE WILL PROTECT OUR HEALTH INFORMATION, YOUR RIGHTS AS A PATIENT AND OUR COMMON PRACTICES IN DEALING WITH PATIENT HEALTH INFORMATION. PLEASE REFER TO THAT NOTICE FOR FURTHER INFORMATION

USES AND DISCLOSURES OF HEALTH INFORMATION:

WE WILL USE AND DISCLOSE YOUR HEALTH INFORMATION IN ORDER TO TREAT YOU OR TO ASSIST OTHER HEALTH CARE PROVIDERS IN TREATING YOU. WE WILL ALSO USE AND DISCLOSE YOUR HEALTH INFORMATION IN ORDER TO OBTAIN PAYMENT FOR OUR SERVICES OR TO ALLOW INSURANCE COMPANIES TO PROCESS INSURANCE CLAIMS FOR SERVICES RENDERED TO YOU BY US OR OTHER HEALTH CARE PROVIDERS. FINALLY, WE MAY DISCLOSE YOUR HEALTH INFORMATION FOR CERTAIN LIMITED OPERATIONAL ACTIVITIES SUCH AS QUALITY ASSESSMENT, LICENSING, ACCREDITATION AND TRAINING OF STUDENTS.

USES AND DISCLOSURES BASED ON YOUR AUTHORIZATION:

IN THE FOLLOWING CIRCUMSTANCES, WE MAY DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION:

- TO FAMILY MEMBERS OR CLOSE FRIENDS WHO ARE INVOLVED IN YOUR HEALTH CARE.
- FOR CERTAIN LIMITED RESEARCH PURPOSES.
- FOR PURPOSES OF PUBLIC HEALTH AND SAFETY.
- TO GOVERNMENT AGENCIES FOR PURPOSES OF THEIR AUDITS, INVESTIGATIONS AND OTHER OVERSIGHT ACTIVITIES.
- TO GOVERNMENT AUTHORITIES TO PREVENT CHILD ABUSE OR DOMESTIC VIOLENCE.
- TO THE FDA TO REPORT PRODUCT DEFECTS OR INCIDENTS.
- TO LAW ENFORCEMENT AUTHORITIES TO PROTECT PUBLIC SAFETY OR TO ASSIST IN APPREHENDING CRIMINAL OFFENDERS.
- WHEN REQUIRED BY COURT ORDERS, SEARCH WARRANTS, SUBPOENAS AND AS OTHERWISE REQUIRED BY LAW.

PATIENT RIGHTS:

AS OUR PATIENT, YOU HAVE THE FOLLOWING RIGHTS:

- TO HAVE ACCESS TO AND/OR A COPY OF YOUR HEALTH INFORMATION.
- TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE OF YOUR HEALTH INFORMATION.
- TO REQUEST THAT WE COMMUNICATE WITH YOU IN CONFIDENCE.
- TO RECEIVE NOTICE OF OUR PRIVACY PRACTICES.

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HIPPA Privacy Acknowledgement

I, _____ have received a copy of Dr. Schwartzwald's Summary of Notice of Privacy Practices.

_____ _____
Signature of Patient Date

Optional Disclosures:

Telephone messages may be left on my:

☐ Home Phone _____

☐ Cell Phone _____

☐ Work Phone _____

Dr. Schwartzwald's office has my permission to release information regarding my medical condition to the following:

☐ My Spouse _____
Print Name Contact Number

☐ My Children _____
Print Name Contact Number

_____

_____

_____

_____

_____

_____

☐ Other _____
Print Name Contact Number

_____

_____