PHOENIXVILLE UROLOGIC ASSOCIATES

PETER OSKANIAN, MD.
JEFFREY ROSENBLUM, M.D.
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Phoenixville ☐
Limerick ☐

Date:_____

Patient:_____ Phone:_____
(Last) (First) (M.I.)

Cell:_____

Age:_____ Birthdate:_____ Sex:_____ Social Security No: _____

_____ Marital Status:_____ No of Children:_____
Name of Spouse if married
Name of Parent if child

Address:_____
(Street) (City) (State) (Zip Code)

Occupation:_____

Employed by:_____ Work No:_____

Address:_____

Insurance:_____ ID No:_____

Subscriber:_____ If subscriber not patient, need subscriber's
(Name)

date of birth_____ and Social Security No:_____

Allergies:_____

Your drugstore:_____ Phone No:_____

Name of Preferred Hospital:_____ Referred by:_____

Family Physician:_____ Phone No:_____

Assignment & Release

I request that payment of authorized insurance benefits be made on my behalf to Valley Forge Urological Association for any services furnished me. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits payable to related services. I recognize my financial obligation of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A copy of Valley Forge Urological Association's Notice of Privacy Practices has been made available to me.

Signature of Patient_____
(or legally responsible adult)

824 MAIN STREET
SUITE 203
PHOENIXVILLE, PA 19460
(610) 933-1133 FAX (610) 933-4238

420 W LINFIELD-TRAPPE ROAD
BUILDING B, SUITE 102
LIMERICK, PA 19468
(610) 495-8444 FAX (610) 495-3003

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CONSENT AND RESTRICTION REQUESTS

Patient's Name_____ **Date of Birth**_____

As required by the Health Portability Act of 1996, Phoenixville Urologic Associates (PUA) may not use or disclose your health information without your authorization. Your signature on this form indicates you are giving permission for the uses herein.

_____ **I give my permission to PUA to use my address, phone number and clinical information to contact me, and/or other physicians, with appointment changes, surgery scheduling, prescription messages, test results, laboratory results and/or other related health information.**

If PUA contacts me by phone, I give them permission to leave a phone message on my answering machine, voice mail or cellular phone.

I give the following people permission to receive tests results by phone, pick up prescriptions, medical records, radiology discs, pathology slides, disability forms, work status forms, or school forms on my behalf regarding my health care condition that pertains to my treatment with PUA.

_____ _____

_____ _____

I have been made aware and understand that our office may use an electronic prescription system which allows prescriptions to be electronically sent between doctors and my pharmacy. I understand that my doctor will be able to see information about medications I am already taking, including those prescribed by other providers.

IF YOUR INSURANCE REQUIRES A REFERRAL, IT MUST BE OBTAINED PRIOR TO YOUR VISIT.

Checks returned by your bank are subject to a processing fee. If your account is referred for collection, you will be responsible for collection costs.

___**Yes** ___**No** **Are you a member of Phoenixville Hospital's Senior Circle?**

___**Yes** ___**No** **Are you a member of Phoenixville Hospital's Healthy Woman?**

___**Yes** ___**No** **Would you like to participate in a short patient survey regarding your visit today? If yes, at which phone number?**_____

PATIENT'S SIGNATURE _____ **DATE**_____

PHOENIXVILLE UROLOGIC ASSOCIATES

TODAY'S DATE: __/__/__ NAME: _____ DATE OF BIRTH: __/__/__ AGE: ____
HEIGHT: _____ WEIGHT: _____

CHIEF COMPLAINT: what symptoms are you experiencing that prompted your visit today? (Fatigue, wt loss, pain, bleeding etc.)

_____

_____

PERSONAL: list all personal past illnesses and/or surgeries and when they occurred:

_____

_____

_____

FAMILY HISTORY: check if any serious illnesses in your IMMEDIATE FAMILY:

___STROKE ___HEART DISEASE ___DIABETES ___PROSTATE CANCER ___ARTHRITIS
___CANCER ___ARTHRITIS ___KIDNEY DISEASE ___ RESPIRATORY DISEASE/TB ___ BLEEDING PROBLEMS

Do you have any drug or dietary allergies: _____
Do you have an allergy to latex: YES____ NO____
MEDICATIONS: please list all medications you are taking including over the counter drugs:

_____

_____

_____

SOCIAL HISTORY:

EMPLOYED: YES__ NO__ **OCCUPATION:** _____ **STUDENT:** YES__ NO__

CHILDREN: YES/HOW MANY___ NO__ **MARITAL STATUS:** _____

DO YOU EXERCISE? YES__ NO___ **FREQUENCY:** DAILY__ WEEKLY__ MONTHLY__

ARE YOU ON A SPECIAL DIET? YES__ NO__: IF YES DESCRIBE _____

TOBACCO USE: YES___ HOW MUCH_____ NO___ (IF NO, HAVE YOU EVER SMOKED AND HOW MUCH_____)

ALCOHOL CONSUMPTION: YES___ HOW OFTEN_____NO___ HISTORY OF SUBSTANCE ABUSE: YES___ NO___

RECREATIONAL DRUGS: YES___ NO___ IF YES SPECIFY: _____

SEXUALLY ACTIVE: YES___ NO___ **HISTORY OF STD'S:** YES___NO___ **PREGNANT:** YES___ NO___

REVIEW OF SYMPTOMS: are you currently having problems with your:

EYES:	__YES __NO	**EARS, NOSE, THROAT:**	__YES __NO
LUNGS, BREATHING:	__YES __NO	**DIGESTION, STOMACH:**	__YES __NO
BOWEL MOVEMENTS:	__YES __NO	**BLADDER PROBLEMS:**	__YES __NO
HEART PROBLEMS:	__YES __NO	**APPETITE/ CHANGE IN WEIGHT:**	__YES __NO
BLEEDING PROBLEMS:	__YES __NO	**NUMBNESS/TINGLING:**	__YES __NO
JOINT ACHES/PAINS:	__YES __NO	**DEPRESSION/ANXIETY:**	__YES __NO
EPILEPSY/ SEIZURES:	__YES __NO	**HEPATITIS:**	__YES __NO

PHYSICIANS SIGNATURE:_____ **DATE:** _____

OFFICE USE ONLY: AUA SCORE_____ **SHIM SCORE:**_____