# GRANT DISICK, M.D.
## U R O L O G Y

### OFFICE USE ONLY

Today's Date: ____/____/____

Chart Number: _____

### PATIENT INFORMATION

Patient Name: Last _____ First _____ MI _____

Gender: ☐ Male ☐ Female

Date of Birth: ____/____/____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security Number: _____

Driver's License Number: _____

Email Address: _____

Permanent Address: _____

City _____ State _____ Zip _____

Home Phone: (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____

Local Address (If other than Permanent): _____

City _____ State _____ Zip _____

Local Phone: (____) _____

Referred to our office by: _____

### EMPLOYMENT INFORMATION

Employer: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

Employer Address: _____

City _____ State _____ Zip _____

Employer Phone: (____) _____

### EMERGENCY CONTACT INFORMATION

Person to Contact in Case of Emergency: Last _____ First _____ MI _____

Relationship: _____

Emergency Contact Phone: (____) _____

### INSURANCE INFORMATION

#### Primary Insurance

Primary Insurance Company: _____

Policy Holder Name (if not Medicare): Last _____ First _____ MI _____

Policy Holder Address: _____

City _____ State _____ Zip _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Social Security Number: _____

Employer: _____

Employer Address: _____

City _____ State _____ Zip _____

Employer Phone: (____) _____

Date of Birth: ____/____/____

#### Secondary Insurance

Secondary Insurance Company: _____

Policy Holder Name: Last _____ First _____ MI _____

Policy Holder Address: _____

City _____ State _____ Zip _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Social Security Number: _____

Employer: _____

Employer Address: _____

City _____ State _____ Zip _____

Employer Phone: (____) _____

Date of Birth: ____/____/____

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UROLOGY

## Confidential History Form - Male

| Last Name | First Name | Date of Birth | Today's Date |
|---|---|---|---|
| | | | |

Why are you consulting a Urologist? _____

**ALLERGIES:** ❑ None. _____

**CURRENT PRESCRIPTION MEDICATIONS:** ❑ None

| Name of Drug | MG Dosage | # times a day | Name of Drug | MG Dosage | # times a day |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**SURGICAL HISTORY (Incuding year):**

❑ Appendix _____
❑ Gall Bladder _____
❑ Hernia _____
❑ Heart Bypass _____

Please list any other surgeries and year of operation.

_____ _____
_____ _____
_____ _____
_____ _____

**MEDICAL HISTORY:**

❑ Heart
❑ Cholesterol
❑ Diabetes
❑ High Blood Pressure
❑ Cancer
❑ Stroke/TIA

Please list any other medical conditions.

_____
_____
_____
_____
_____

**FAMILY HISTORY:**

❑ Heart Disease
❑ Diabetes
❑ Cancer
❑ Kidney Failure
❑ Easy Bleeding

Please list any other family conditions.

_____
_____
_____
_____

**SOCIAL HISTORY:**

(Check one) ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated ❑ Other

Smoker: ❑ Yes (how many packs a day? ____) ❑ Not anymore (since when? _____) ❑ Never

Alcohol: ❑ Yes (how many drinks a day? ____) ❑ Not anymore (since when? _____) ❑ Never

Coffee: _____ cups a day Tea: _____ cups a day. Soda: _____ cans a day.

## REVIEW OF SYSTEM Have you recently had any of the following symptoms? (Check all that apply)

**Constitutional Symptoms**
- ❑ Fever
- ❑ Weight loss
- ❑ Chills

**Ears / Nose / Mouth / Throat**
- ❑ Hearing loss
- ❑ Nasal stuffiness
- ❑ Sore throat

**Eyes**
- ❑ Blurry vision
- ❑ Double vision
- ❑ Cataracts

**Cardio Vascular**
- ❑ Chest pain
- ❑ Swollen ankles
- ❑ Irregular heart beat

**Respiratory**
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Chronic cough

**Genitourinary**
- ❑ Incontinence
- ❑ Painful urination
- ❑ Blood in urine

**Musculoskeletal**
- ❑ Chronic back pain
- ❑ Chronic neck pain
- ❑ Sore muscles

**Skin**
- ❑ Rash
- ❑ Persistent itching
- ❑ Skin cancer history

**Neurological**
- ❑ Numbness
- ❑ Tingling
- ❑ Dizziness

**Hematology**
- ❑ Swollen glands
- ❑ Abnormal bleeding
- ❑ Transfusion

**Other symptoms:**

_____

_____

_____

_____

_____

_____

## URINARY FREQUENCY SCORE Circle the number of the most accurate answer.

**1. Incomplete emptying:** Over the past month, how often have you had a sensation of not emptying your bladder completely after urinating?
**0.** Not at all **1.** Less than 1 time in 5 **2.** Less than half the time **3.** About half the time **4.** More than half the time **5.** Almost always

**2. Frequency:** Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?
**0.** Not at all **1.** Less than 1 time in 5 **2.** Less than half the time **3.** About half the time **4.** More than half the time **5.** Almost always

**3. Intermittency:** Over the past month, how often have you found that you stopped and started again several times when you urinated?
**0.** Not at all **1.** Less than 1 time in 5 **2.** Less than half the time **3.** About half the time **4.** More than half the time **5.** Almost always

**4. Urgency:** Over the past month, how often have you found it difficult to postpone urination?
**0.** Not at all **1.** Less than 1 time in 5 **2.** Less than half the time **3.** About half the time **4.** More than half the time **5.** Almost always

**5. Weak-stream:** Over the past month, how often have you had a weak stream?
**0.** Not at all **1.** Less than 1 time in 5 **2.** Less than half the time **3.** About half the time **4.** More than half the time **5.** Almost always

**6. Straining:** Over the past month, how often have you had to push or strain to begin urination?
**0.** Not at all **1.** Less than 1 time in 5 **2.** Less than half the time **3.** About half the time **4.** More than half the time **5.** Almost always

**7. Nocturia:** Over the past month, how many times did you get up to urinate after going to bed until the time you got up in the morning?
**0.** None **1.** 1 time **2.** 2 times **3.** 3 times **4.** 4 times **5.** 5 or more times

**8. Quality of Life Due to Urinary Symptoms:** If you were to spend the rest of your life with your current urinary condition, how would you feel?
**0.** Delighted **1.** Pleased **2.** Mostly satisfied **3.** Mixed **4.** Mostly dissatisfied **5.** Unhappy/Terrible

## ERECTILE FUNCTION SCORE (Check one) Over the past 6 months:

1. Confidence that you could get and keep an erection? ❑ None ❑ Very low ❑ Low ❑ Moderate ❑ High ❑ Very high

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?
❑ Never ❑ Almost never ❑ Less than half the time ❑ Half the time ❑ More than half the time ❑ Almost always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?
❑ Never ❑ Almost never ❑ Less than half the time ❑ Half the time ❑ More than half the time ❑ Almost always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?
❑ Always difficult ❑ Extremely difficult ❑ Very difficult ❑ Difficult ❑ Slightly difficult ❑ Not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?
❑ Never ❑ Almost never ❑ Less than half the time ❑ Half the time ❑ More than half the time ❑ Almost always

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UROLOGY

www.gdurology.com

Privacy Officer: Grant Disick, MD
Effective: August 1, 2010 ■ 561.487.5506

# Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.**

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the Privacy Officer at this practice.

## Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record. all employees. staff. and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, businesses (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is invoked, only the minimum necessary information needed to accomplish the task will be shared.

## How we may use and Disclose Medical Information about You

The following categories describe different ways that we may use and disclose medical information about you to provide you with medical treatment without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

## For Treatment

We may use medical information about you to provide you with medical treatment or services. Example In treating you for a specific condition. we may need to know if you have allergies that could interact with medications we prescribe for the treatment to your insurance company for payment.

## For Payment

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date. and codes identifying your diagnosis and treatment to your insurance company for payment.

## For Health Care Operations

We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: we may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

### Other Uses or Disclosures That Can Be Made Without Consent or Authorization

-- As required during an investigation by law enforcement agencies
-- To avert a serious threat to public health or safety
-- As required by military command authorities for their medical records
-- In response to a legal proceeding
-- To a coroner or medical examiner for identification of a body
-- If an inmate, to the correctional institution or law enforcement official
-- As required by the US Food and Drug Administration (FDA)
-- Other healthcare providers' treatment activities
-- Other covered entities' and providers' payment activities
-- Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
-- Uses and disclosures required by law
-- Uses and disclosures in domestic violence or neglect situations
-- Health oversight activities
-- Other public health activities
-- Faxes from and to your pharmacy

We may contact you to provide appointement reminders or information about treatment alternatives or other related benefits and services that may be of interest to you.

### Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written consent. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

### Your Individual Rights Regarding Your Medical Information

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filling a complaint.

### Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment health care operations or someone who is involved in your care for the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions. you must submit your request in writing to the Privacy Officer at this practice. In your request you must tell us what information you want to limit.

### Right to Request Confidential Communications

You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications. you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accomodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden to the practice.

### Right to Inspect and Copy

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes: information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information about you. You must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

## Right to Amend

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, or is not part of the medical information kept at this practice, is not part of the information which would be permitted to inspect and copy, or which we deem to be inaccurate or incomplete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

## Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current notice, please request one in writing from the Privacy Officer at this practice.

## Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice with the effective date in the upper right corner of the first page.

GRANT DISICK, M.D.
UROLOGY

## RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I _____have reviewed / received a copy of Dr. Grant Disick's Notice of Privacy Practices.

_____ _____
Patient's Signature of Guardian's Signature Date

### Medical Authorization and Lifetime Patient Signature

I request that payment of authorized insurance benefits either to me or on my behalf be made payable to GRANT DISICK, M.D., P.A. for any services furnished me by that doctor. I authorize any holder of medical information to release to the Health Care Financing Administration (HCFA) and it's agents any information needed to determine these benefits payable for related services. I also understand that if my insurance company does not provide payment to GRANT DISICK, M.D., P.A. that I will be billed and I agree to pay for said services. I agree to pay for services rendered, including attorney's fee, collection charges and court costs necessary to affect payment of this account. I also understand that interest charges of 1.5% per month may be charged should my account become delinquent.

I understand that I am entering into a contractual relationship with GRANT DISICK, M.D., P.A. / GRANT DISICK, M.D. for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by GRANT DISICK, M.D., P.A./GRANT DISICK, M.D., I and or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against GRANT DISICK, M.D., P.A. / GRANT DISICK, M.D.

Furthermore, should a meritorious medical malpractice care or cause of action be initiated or pursued, I and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same specialty as GRANT DISICK, M.D. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case.

In further consideration for this, I, GRANT DISICK, M.D., agree to the same stipulations.
A photocopy of this authorization shall be considered as effective and valid as the original.

**Your signature is required which will allow us to bill your insurance company.**

_____ _____
Patient's Signature or Guardian's Signature Date

_____ _____
Grant Disick, M.D. Date