SUNCOAST UROLOGY
Review of Systems

Please review and circle any current issues.

Constitutional Symptom
Fever
Chills
Headache
Weight Change

Gastrointestinal
Abdominal pain
Nausea/vomiting
Indigestion/heartburn
Bowel Changes

Eyes
Blurred vision
Double vision
Pain
Other _____________

Cardiovascular
Chest pain
Varicose veins
High blood pressure
Other _______________

Respiratory
Wheezing
Frequent cough
Shortness of breath
Other ____________

Allergic/Immunologic
Hay Fever
Drug allergies
Other ______________

Integumentary
Skin rash
Boils
Persistent itch
Other _________________

Hematologic/Lymphatic
Swollen glands
Blood clotting problem
Other ________________

Neurological
Tremors
Dizzy spells
Numbness or Tingling
Other ______________

Musculoskeletal
Joint pain
Neck pain
Back pain
Other ____________

Psychologic
Are you generally satisfied with your life?
Other ________________

Endocrine
Excessive thirst
Too hot/cold
Tired/sluggish
Other _____________

Ear/Nose/Throat/Mouth
Ear infection
Sore throat
Sinus problems
Other ______________

Patient Name ____

Signature: ____

International Prostate Symptom Score (IPSS)

Patient Name: Date of Birth: Today's Date:

Determine Your BPH Symptoms

Circle your answers and add up your scores at the bottom.

Over the past month	Not at all	Less than one time in five	Less than half the time	About half the time	More than half the time	Almost always
Incomplete emptying – How often have you had the sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Frequency – How often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Intermittency – How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Urgency – How often have you found it difficult to postpone urination?	0	1	2	3	4	5
Weak stream – How often have you had a weak urinary stream?	0	1	2	3	4	5
Straining – How often have you had to push or strain to begin urination?	0	1	2	3	4	5
Sleeping – How many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	None 0	One Time 1	Two Times 2	Three Times 3	Four Times 4	Five or More Times 5
Add Symptom Scores:	+	+	+	+	+	

Total International Prostate Symptom Score = ______

1 – 7 mild symptoms | 8 – 19 moderate symptoms | 20 – 35 severe symptoms
Regardless of the score, if your symptoms are bothersome you should notify your doctor.

Quality of Life (QoL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Have you tried medications to help your symptoms?	Yes	No

Did these medications help your symptoms? (circle)

1	2	3	4	5	6	7	8	9	10

No Relief *Complete Relief*

Would you be interested in learning about a minimally invasive option that could allow you to discontinue your BPH medications?	Yes	No

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SUNCOAST UROLOGY, P.A.

HEALTH INSURANCES ARE NOW REQUIRING WE ASK THE FOLLOWING QUESTIONS OF EACH PATIENT:

PATIENT NAME ______________________________ DATE ______________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you had a colonoscopy in the last 10 years?

   YES ______________ NO _____________

2. Have you had a pneumonia vaccination in the last 5 years?

   YES ______________ NO _____________

3. Have you had a flu shot this year?

   YES ______________ NO _____________

4. What is your email address? _____________________________________
   (If you do not have an email, please write NONE)

SUNCOAST UROLOGY, P.A.

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Hudson, Florida 34667
727-862-8548

David Buethe, M.D.
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Arnie Tannenbaum, M.D.
Candace Remington, N.P.

11373 Cortez Blvd. Suite209
Brooksville, Florida 34613
352-596-0786

PATIENT INFORMATION

NAME: ____
Last First M.I.

ADDRESS: ____

CITY: ________________________________ STATE: _________ ZIP CODE ______________________

PRIMARY PHONE # __________________________SECONDARY PHONE NUMBER __________________________

SEX __________ MARITAL STATUS ______________________________ DATE OF BIRTH: ____/_____/______

SOCIAL SECURITY NUMBER ______________________

PRIMARY CARE PHYSICIAN ___________________________REFERRING PHYSICIAN___________________________

PHARMACY: ____________________________________ PHARMACY PHONE # ____________________________

EMERGENCY CONTACT: _____________________________________ PHONE ____________________________

INSUARNACE INFORMATION

Primary Insurance: ___________________________________ ID# _______________________________________

Group # ___________________________________Phone # ____

Subscriber Name (if patient write self) ____

Subscriber Date of Birth (if applicable) ____/____/_______

Subscriber Social Security (if applicable) _________________________

Secondary Insurance ______________________________________ID# ____________________________________

Group # ___________________________________ Phone # ____

SUNCOAST UROLOGY

HIPPA MEDICAL RELEASE INFORMATION

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Please list names of any person(s) whom we may inform about your general medical Condition and your diagnosis (including treatment, payment and healthcare operations).

Name______________________Relationship ________________ Phone#__________________

Name______________________Relationship ________________ Phone#__________________

Name______________________Relationship ________________ Phone#__________________

Please indicate if you want correspondence from our office sent in a Sealed envelope marked "Confidential". YES__________ NO_________

Can confidential messages (i.e. appointment reminders, lab results, etc) be Left on answering machine or voice mail. YES____________NO_________

Allow access to pharmacy thru ePrescription. Yes____________NO__________

PATIENT NAME____

PATIENT OR GUARDIAN
SIGNATURE____

DATE________________________

We are required by Law to maintain the privacy of your personal health Information, and to provide you notice of our legal duties and privacy Practices and adhere to this notice. We reserve the right to make changes To this notice. We will post a notice that the notice has been changed and The effective date of this change, copies will be made available.

If you receive no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.

SUNCOAST UROLOGY
LIFETIME AUTHORIZATION, INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. ***TREATMENT AUTHORIZATION*** – I, the below named patient, do hereby give Suncoast Urology consent for medical treatment.

II. ***RELEASE OF INFORMATION*** – I do hereby authorize any physician of this group examining and/or treating me to release to any third party payor (such as an insurance company or governmental agency, i.e., Medicare, Medicaid), any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis. **I have been offered a copy of the privacy policy by Requesting it verbally or by a written request. Our privacy policy is posted in our waiting room.**

III. ***PHYSICIAN INSURANCE ASSIGNMENT*** – I hereby authorize payment directly to any physician of this group examining or treating me any surgical and/or medical benefits herein specified and otherwise payable to me for their services and described but not to exceed the reasonable and customary charge for these services.

IV. ***MEDICARE/MEDICAID*** – **Patient's certified authorization to release information and payment request.** I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act it correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Children and Families or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

V. ***I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN OFFICE.*** This assignment will remain in effect until revoked by me in writing.

We are committed to providing you with the best possible care. If you have medical insurance, we will be glad to help you receive your maximum benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Your insurance is an agreement between you and the insurance company- not an agreement between the doctor and the insurance company. As the patient, you further understand that you are ultimately responsible for the charges for medical care being rendered to you.

Our fees are generally considered to fall within the acceptable range by most companies. Our fees are considered USUAL, CUSTOMARY AND REASONABLE by most insurance companies.

This is to inform you that one or all of the physicians may have a partnership in the following Bay Area Partners, LTD, UMS, South Florida Mobile Lithotripsy, and or Bayonet Point Surgery Center.

This is to inform you if you do not show up for your scheduled appointment there will be a $25.00 charge, which you will be responsible for, unless you give a 24 hour notice.

We bill all Medicare claims as well as PPO, HMO and managed care plans that we participate with. Patients will be asked to pay all deductibles and co-pays at time of service. It is also the patient's responsibility to obtain all referrals and/or authorization numbers as required by their insurance plan. Changes in your insurance coverage must be given to the receptionist prior to your appointment.

____________________________ ____________________________
PATIENT NAME PATIENT SIGNATURE

____________________________ ____________________________ __________
GUARANTOR NAME GUARANTOR SIGNATURE (IF OTHER THAN PATIENT) DATE

LIFETIME AUTHORIZATION, MEDIGAP (SECONDARY INSURANCE) SIGNATURE

____________________ ____________________ ____________________
PATIENT NAME HEALTH INSURANCE COMPANY POLICY NUMBER

I request that payment of authorized MEDIGAP/Secondary Insurance benefits be made on my behalf to Suncoast Urology for any services furnished me by Suncoast Urology. I authorize any holder of medical information about me to release to

____________________________ any information needed to determine benefits or the benefits payable for related services
(MEDIGAP/SECONDARY INSURANCE CO)

____________________________ ____________________________
PATIENT SIGNATURE DATE

SUNCOAST UROLOGY, P.A.

RELEASE OF MEDICAL INFORMATION

I hereby authorize that my medical records be released from:

Barry T. Sadler, M.D.
Arnie B. Tannenbaum, M.D.
Kevin S. Spires, M.D.
David Buethe, M.D.
Candace Remington, APRN

7614 Jacque Road Suite A
Hudson, FL 34667
(727) 862-8548
Fax: (727) 863-4530

To the following listed physician's office:______________________________________
:

____
Date

______________________________ ____
Patient Name Patient Signature

____
Date of Birth

____
Social Security Number

SUNCOAST UROLOGY, P.A

Patient Name: ____________________________________ Date: _________________

Age: ______ Date of Birth: _________________ Referring Physician: ____________________

1) State the reason or symptom that brought you to the Urologist today.
   ____
   ____
2) Have you seen a Urologist before or had urologic problems requiring treatments in the past?
   ____
   ____
3) List past and current medical conditions:

4) Past surgical procedures (please list date):

Date:		Date:	

5) Current medications with dosage (include over the counter items such as: aspirin, anti-inflammatories, vitamins, herbal supplements,etc)

6) Please list allergies to medications and reactions:

Medications	Reactions

7) Are you allergic to seafood or Iodine dye? Yes No

8) Have any members of your family had urologic problems? (For example: kidney stones, prostate issues, kidney or bladder cancer, uti's etc)

____

9) Please list your family medical history, please include your relation to that member. (for example Diabetes, Heart Disease, Cancer, etc)

____

10) Do you currently use Tobacco? Yes No Amount per day: ______________________

11) Are you a former smoker? Yes No Year Quit: __________________

12) Alcohol Consumption: Yes No Amount per day: _________________

13) Caffeine Consumption: Yes No Amount per day: ____________________

14) Citrus Products: Yes No Amount per day: _______________________

15) Martial Status: Single Married Divorced Widowed.

16) Occupation: (if retired, specify your previous occupation) _________________________