

UNIVERSITY UROLOGY ASSOCIATES
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PATIENT INFORMATION

Today's Date _____

Name of Patient _____ Male ____ Female ____

Home address: _____ Apt #: _____

City _____ State _____ Zip Code _____

Home Phone _____ Work _____ Cell _____

Email address: _____

Date of Birth _____ Age ____ SS# _____

Occupation _____ Company _____ Marital Status _____

Business Address: _____

Referring Physician _____ Phone _____

INSURANCE INFORMATION

Primary Medical Insurance Company _____

Policy Number _____ Group Number _____

Name of Insured _____ Date of Birth (Insured) _____

Does your insurance require a referral to receive services? __YES __NO, Have you obtained one? __Yes
__No , If you have is it a written or electronic referral? Referral# _____

Secondary Medical Insurance Company _____

Policy Number _____ Group Number _____

Name of Insured _____ Date of Birth (Insured) _____

HIPPA ACKNOWLEDGEMENT

I hereby acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of UNIVERSITY UROLOGY ASSOCIATES.

Signature:

MEDICAL HISTORY (please use back of page to supply any additional information for the following)

Reason for Today's Visit: _____

Allergies: Medication/Food _____

Previous Illnesses _____

Previous Surgeries _____

Surgeon's Name: _____ Where Performed: _____

Current Medications: _____

Vitamins and/or Herbal Supplements: _____

Do you smoke? YES NO If yes, how much? _____

Do you drink alcohol? YES NO If yes, how much? _____

Do you take aspirin? YES NO If yes, how much? _____

Have you ever had any problems with or been treated for any of the following:

- | | | | |
|----------------------|-------|-----------------|-------|
| Nerves | _____ | Diabetes | _____ |
| Heart Trouble | _____ | Kidney disease | _____ |
| Heart Attack | _____ | Urine infection | _____ |
| Stroke | _____ | Blood in urine | _____ |
| High Blood Pressure | _____ | Kidney stone | _____ |
| Breathing difficulty | _____ | Prostate gland | _____ |
| Stomach/ulcers | _____ | Back trouble | _____ |
| Colon trouble | _____ | | |

FAMILY HISTORY

Indicate health status (Excellent, Good, Poor or if Deceased indicate Age and Cause) for the following:

Mother: _____ Father: _____

Brother(s): _____ Sister(s): _____

Have any men in your family had prostate cancer? _____ Relationship _____

Number of Children: _____

Pharmacy Name: _____

Pharmacy Telephone: _____