PROGRESSIVE UROLOGY

315 East Shore Road
Manhasset, NY 11030
P: 516.487.5577
F: 516.487.2947

69-02 Austin Street (3rd Floor)
Forest Hills, NY 11375
P: 718.544.4443
F: 516.487.2947

27-47 Crescent Street (Suite 206)
Astoria, NY 11102
P: 718.728.3200
F: 718.728.5586

Dimitri N. Kessaris, MD – Director *Diplomate, American Board of Urology*

Michael Ohebshalom, MD *Diplomate, American Board of Urology*

Sherman Chan, MD *Diplomate, American Board of Urology*

NAME: _____ Chart#: _____

STREET: _____ Sex: _____ Marital Status: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

DATE OF BIRTH: _____ AGE: _____ SSN: _____

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE _____

EMAIL: _____

OCCUPATION: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: _____

PHONE: _____

RELATIONSHIP: _____

NAME OF SPOUSE _____ SPOUSE'S BIRTHDATE _____

SPOUSE'S OCCUPATION _____ SPOUSE'S EMPLOYER _____

SPOUSE'S EMPLOYER'S ADDRESS: _____

SPOUSE'S EMPLOYER PHONE# _____

WHO IS YOUR PRIMARY CARE PHYSICIAN: _____ PHONE: _____

HOW WERE YOU REFERRED TO OUR OFFICE: _____

Insurance Information:

Primary Insurance: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Insured's name, if not the same:

NAME: _____

INSURED'S SS# _____ **INSURED'S DATE-OF-BIRTH** _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Insured's name, if not the same: _____

Name: _____

INSURED'S SS# _____ INSURED'S DATE-OF-BIRTH _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Dimitri N. Kessaris, MD, PC for any services furnished to me by Dr. Kessaris or his authorized agents. I authorize any holder of medical information about me to be released to my insurance carriers or the Healthcare Financing Administrations or its agents any information needed to determine these benefits or benefits payable for related services. Furthermore, I understand the annual deductible and co-insurance amounts are my responsibility. If I have assigned benefits to any other party (Medicare Managed Care or other plans we do not participate with) rendering this office ineligible for payment. I understand that I will be responsible for the entire bill for service rendered. If your account becomes delinquent you will be responsible for 18% interest (APR), collection fees of 25% of the balance due, in addition to any applicable penalties.

SIGNED _____ DATE _____

SIGNED _____ DATE _____

SIGNED _____ DATE _____

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Sherman Chan, MD
Diplomate, American Board of Urology

GenFemale

Name: _____ Date: _____

Referring Doctor: _____ Primary Doctor: _____

Occupation: _____ Age: _____

Why are you seeing the doctor today? _____

How long have you had this problem? _____ _

Are there any symptoms **that go along** with the problem/pain? _____

Have you tried any **medicine/treatment** for this problem/pain? _____

Height: _____ Weight: _____

PRESENT UROLOGIC COMPLAINTS:

Please CHECK OFF any of the following urologic problems you are CURRENTLY experiencing:

- ☐ Abdominal Pain – location: _____
- ☐ Back Pain – Right/Left/Lower Back
- ☐ Flank Pain – Right/Left
- ☐ Painful Urination – mild/moderate/severe
- ☐ Straining to Urinate – occasional/always
- ☐ Frequency of Urination – every ___ hour(s)
- ☐ Urination Hesitancy – occasional/always
- ☐ Weak or Slow Stream – occasional/always
- ☐ Incomplete Bladder Emptying – occasional/always
- ☐ Urgency to Urinate – occasional/always
- ☐ Dribbling – occasional/always
- ☐ Urine Leakage with coughing or sneezing
  If yes: ___ #pads/day
- ☐ Urine leakage associated with urgency to urinate
  If yes: ___ #pads/day
- ☐ Blood in the Urine
- ☐ Urine Odor
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chills
- ☐ Fever
- ☐ Nausea
- ☐ Vomiting
- ☐ Weight Loss
- ☐ Vaginal Discharge

How many times do you urinate at night? ___ per night

Do you have a history of Urinary Tract Infections? ___ Yes ___ No If yes, how many in the last 6 months? _____

Do you have a history of Kidney Stones? ___ Yes ___ No

Do **YOU** have a *history* of:

Kidney Cancer?: ___ Yes ___ No

Bladder Cancer?: ___ Yes ___ No

Do you have a *FAMILY HISTORY* of:

Kidney Cancer?: ___ Yes ___ No

Bladder Cancer?: ___ Yes ___ No

Have you ever been pregnant? ____ No ____ Yes:

If "yes," # vaginal births ____ (#) # of Elective Abortions ____ (#)

# of C-Sections ____ (#) # of Miscarriages ____ (#)

Please use the following space to tell us of any urologic problems bothering you that were not covered above:

_____

_____

SOCIAL HISTORY:

Marital Status: (Please indicate the number of years)

____ Single ____ Married ____ Separated ____ Divorced ____ Widowed ____ Life Partner

Alcohol Consumption: ____None ____Yes Occasional/Social # of drinks per day ____

TOBACCO USE: ____None ____Yes #____ Packs/day #____Cigarettes/day ____Smokeless Tobacco

DID YOU EVER SMOKE? ____Yes ____No

IF YES, #____ Packs/day #____Cigarettes/day

WHEN DID YOU QUIT? #____months/years ago

Recreational Drugs: ____None ____Yes If yes, please list: _____

CURRENT MEDICATIONS: Please list ALL medications you are currently taking including over the counter meds

Drug Name:	Strength:	Directions/ How you take it:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Attach list if necessary)

***ALLERGIES*:** Please list ALL types (Drug, Seasonal, Pets, environmental, Foods)

_____

_____

_____

PHARMACY NAME: _____ **Phone** #: _____

Fax#: _____

******IF YOU DO NOT HAVE THE ABOVE INFORMATION WITH YOU, PLEASE CALL OUR OFFICE WHEN YOU GET HOME AND GIVE IT TO US!!!!!!!!!!!***

PAST MEDICAL HISTORY:

Please CIRCLE if you have or have had any of the following diseases or conditions:

ADD
ADHD
Alcoholism
Allergies
Alzheimer's Disease
Anemia _____
Aneurysm
Angina
Anorexia
Anxiety Disorder
Arthritis
Arrhythmia
Aortic Aneurysm
Aortic Stenosis
Aortic Insufficiency
Asthma
Atrial Fibrillation
Back pain
BPH
Bi-polar Disorder
BLADDER CANCER
Bleeding Disorder
Blindness
Brain Tumors
Breast Cancer
Bronchitis
Cataracts
Cerebrovascular Disease
Cholecystitis
Cholelithiasis
Chronic Fatigue Syndrome
Chronic Liver Disease
Chronic Lung Disease
CHRONIC RENAL INSUFFICIENCY
CHRONIC RENAL FAILURE
Colitis
Constipation
Colon Cancer
Colon Condition
Congenital Heart Disease
Congenital Heart Failure
Crohn's Disease
Deafness
Deep Vein Thrombosis
Depression
Diabetes - Non-Insulin Dependant
Diabetes - Insulin Dependant
Diabetes - Uncontrolled
Diarrhea
Eating Disorder
Ear Infections
Emphysema
Enlarged Heart
Epilepsy
Fibrocystic Breast Disease
Fibromyalgia
Gastric Cancer
GERD
GLAUCOMA
Goiter
GOUT
Hay Fever
Heart Attack
Heart Disease
Heart Valve Problem
Heart Murmur
Hemorrhoids
Hepatitis
Herniated Disc
Hiatal Hernia
High Cholesterol
High Blood Pressure
HIV (AIDS)
Impaired Glucose Tol.
Infertility
Irritable Bowel Disease
Inflam. Bowel Disease
KIDNEY CANCER
KIDNEY DISEASE
KIDNEY INFECTION
KIDNEY STONES
Infectious Disease
Laryngeal Cancer
Leukemia
Liver Disease
Lung Disease
Lung Cancer
Lymphoma
Malaise
Melanoma
Mental Illness
Migraine
Mitral Stenosis
Mitral Insufficiency
Mitral Valve Prolapse
Mumps
Nervous Breakdown
Obesity
Osteopenia
Osteoporosis
Pancreatitis
Pancreatic Cancer
Peptic Ulcer
Phlebitis
Pituitary Disease
Polio
Pulmonary Embolism
Rectal Fissure
Rectal Cancer
Rheumatic Fever
Sexually Trans. Disease
Sickle Cell Anemia
Stroke
Suicide Attempt
THYROID DISEASE
Tuberculosis

Other: _____

_____

FAMILY HISTORY

Please CIRLCE which family member has/had any of the following: (Mother, Father or Siblings)

Arthritis
Bedwetting
Bladder Cancer
Cancer Site _____
Crohn's Disease
Depression
Diabetes
Gout
Heart Attack
Hypertension
Kidney Cancer
Kidney Stones
Leukemia
Malignant Melanoma
Multiple Sclerosis
Laryngeal Cancer
Pancreatic Cancer
Prostate Cancer
Stroke
Thyroid Disease
Tuberculosis

Other: _____

_____

SURGICAL HISTORY;

Please CIRCLE if you have had any of the following surgeries and date of surgery:

Amputation
Angioplasty
Aortic Aneurysm Repair
Appendectomy
Arthroscopic Surgery
Back Surgery
Bariatric Surgery
Bladder Surgery
Bowel Resection
Brain Surgery
Breast Surgery
CABG
Carotid Artery Surgery
Carpal Tunnel Surgery (L or R or Both)
Cataract Surgery (L or R or Both)
Cervical Spine Surgery
Cholecystectomy
Colon Resection
Colonoscopy
Corneal Surgery (L or R or Both)
CYSTOSCOPY
CYSTO-TUR FULGURATION
Delivery's (Vaginal or C-Section)
Ear Surgery (L or R or Both)
EGD
ESWL / KIDNEY STONE LITHOTRIPSY
Eye Surgery (L or R or Both)
Facial Surgery
Foot Surgery (L or R or Both)
Gastric Surgery
Hand Surgery (L or R or Both)
Heart Surgery
Heart Transplant
Hemorrhoidectomy
Herniorrhaphy
Hip Surgery
Hysterectomy – Complete
Ilioconduit
Ileostomy
Inguinal Herniorrhaphy
Knee Surgery (L or R or Both)
Laminectomy
Laparascopy
Laparatomy
Leg Surgery (L or R or Both)
Liver Surgery
Lumpectomy
Lung Surgery
Lymphatic Node Dissection
Lysis Adhesions
Mastectomy
Mastoid Surgery
Nasal Surgery
NEPHRECTOMY – KIDNEY REMOVAL
Neprolithotomy
Pacemaker Insertion
Parathyroidectomy
PEG
PE Tubes
Pilondial Cyst Incision
RENAL TRANSPLANT
Rotator Cuff Surgery
Sinus Surgery
Skin Grafting
Splenectomy
Stomach Surgery
Tonsil Surgery
Thyroid Surgery
TMJ Surgery
Umbilical Hernia
URETEROSCOPY
Vein Stripping
Ventral Hernia Repair

Other: _____

_____

REVIEW OF SYSTEMS:

******Please circle any problems you currently have today.***

Constitutional
Aches/Pains
Appetite Changes
Bruises Easily
Fever
Chills
Hot Flashes
Night Sweats
Fatigue
Generalized Weakness
Insomnia
Swollen Glands
Anorexia
Weight Loss
Weight Gain
Other _____

Eyes
Blindness
Blurred Vision
Double Vision
Eye Pain
Other _____

Allergic/Immunologic
Seasonal
Drug
Animal
Environmental
Other _____

Gastrointestinal
Indigestion/Heartburn
Nausea/Vomiting
Abdominal Pain
Bloody Stools
Abdominal Cramps
Diarrhea
Constipation
Change in Bowel Habits
Flatulence
Gas
Rectal Bleeding
Tarry Stools
Other _____

Cardiovascular
Chest Pain/ Angina
Dyspnea on Exertion
Edema
Hardening of the Arteries
Low Exercise Tolerance
Orthopnea
Pain/Cramps w/ Exercise
Palpitations
Skipped Heart Beats
Swelling
Other _____

Musculoskeletal
Back Pains
Joint Pains
Neck Pain/Stiffness
Muscle Cramps
Muscle Weakness
Other _____

Ears/Nose/Throat
Ear Infection
Sinus Problems
Sore Throat
Other _____

Endocrine
Excess Thirst
Tired/Sluggish
Heat/Cold Intolerance
Other _____

Neurological
Headache
Dizzy Spells
Balance Problems
Numbness/Tingling
Tremors
Leg or Arm Weakness
Memory Loss
Speech Problems
Other _____

Respiratory
Frequent Cough
Shortness of Breath
Wheezing
Other _____

Hematological/Lymphatic
Swollen Glands
Blood Clotting Problems
Bleeding Problems
IV Drug Use
Sickle Cell
Other _____

Psychological
Not Satisfied with Life
Anxious
Depressed
Considered Suicide
Other _____

Skin
Acne
Boils
Persistent Itch
Skin Rash
Changing Moles
Pigment Changes
Other _____

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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.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical record information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is not in effect.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other healthcare providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes and for obtaining authorization for surgical procedures and prescriptions.

FOR NOTIFICATION: We may use medical information about you to notify a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible, before we share any information, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your healthcare, according to our professional judgment. We will also

use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

PUBLIC HEALTH ACTIVITIES: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

WORKERS COMPENSATION: We may disclose medical information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

LAW ENFORCEMENT: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

ANNOUNCEMENTS: We may use your personal information (name and address) in order to notify you of services available in our office that may be of interest to you. We may also use your information to formally introduce you to new physicians in our practice.

4. YOUR INDIVIDUAL RIGHTS

You have the right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. If you request copies, we will charge you $1.00 for each page, and postage if you want the copies mailed to you.
2. Receive a list of all the times when we shared your medical information for purposes other than treatment, payment, and healthcare operations.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about you medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted to changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of the information.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U. S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRACTICES ACKNOWLEDGMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____ Date _____

IF YOU WOULD LIKE YOUR OWN COPY OF OUR PRIVACY PRACTICES, PLEASE INFORM THE RECEPTIONIST