



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
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Dimitri N. Kessarlis, MD – Director

Michael Ohebshalom, MD

Sherman Chan, MD

Diplomate, American Board of Urology

Diplomate, American Board of Urology

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. Kessarlis, MD, PC for any services furnished to me by Dr. Kessarlis 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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GenMale

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:

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

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:

Do you have a *FAMILY HISTORY* of:

Kidney Cancer?: ___ Yes ___ No

Kidney Cancer?: ___ Yes ___ No

Bladder Cancer?: ___ Yes ___ No

Bladder Cancer?: ___ Yes ___ No

Prostate Cancer?: ___ Yes ___ No

Prostate Cancer?: ___ Yes ___ No If yes, relation to you? _____

Have you had a recent serum PSA test? ___ Yes ___ No ___ Don't know If yes, what is the value? _____ Date _____

Do you have difficulty obtaining erections? ___ No ___ Yes

If yes: ___ Inability to obtain ___ Inability to maintain ___ Problem ongoing for ___ months/ ___ years.

Do you experience premature ejaculation? ___ Yes ___ No

Do you experience a low sex drive? ___ Yes ___ No

Do you suffer from excessive fatigue or tiredness? ___ Yes ___ No

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

Other: _____

FAMILY HISTORY

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

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

Other: _____

SURGICAL HISTORY;

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

Amputation	Eye Surgery (L or R or Both)	NEPHRECTOMY – KIDNEY REMOVAL
Angioplasty	Facial Surgery	Nephrolithotomy
Aortic Aneurysm Repair	Foot Surgery (L or R or Both)	Orchiectomy
Appendectomy	Gastric Surgery	Pacemaker Insertion
Arthroscopic Surgery	Hand Surgery (L or R or Both)	Parathyroidectomy
Back Surgery	Heart Surgery	Penile Implant
Bariatric Surgery	Heart Transplant	PEG
Bladder Surgery	Hemorrhoidectomy	PE Tubes
Bowel Resection	Herniorrhaphy	Pilonidal Cyst Incision
BRACHYTHERAPY – PROSTATE	Hip Surgery	RADIATION FOR PROSTATE CANCER
RADIOACTIVE SEED IMPLANT	HYDROCELECTOMY	RADICAL PROSTATECTOMY
Brain Surgery	Hysterectomy – Complete	RENAL TRANSPLANT
Breast Surgery	Iliioconduit	Rotator Cuff Surgery
BIOPSY OF PROSTATE	Ileostomy	Septoplasty
CABG	Inguinal Herniorrhaphy	Sinus Surgery
Carotid Artery Surgery	Knee Surgery (L or R or Both)	Skin Grafting
Carpal Tunnel Surgery (L or R or Both)	LASER OF PROSTATE	Spermatocectomy
Cataract Surgery (L or R or Both)	Laminectomy	Splenectomy
Cervical Spine Surgery	Laparascopy	Stomach Surgery
Cholecystectomy	Laparatomy	Tonsil Surgery
CIRCUMCISION	Leg Surgery (L or R or Both)	Thyroid Surgery
Colon Resection	Liver Surgery	TMJ Surgery
Colonoscopy	Lumpectomy	TUMT PROSTATE
Corneal Surgery (L or R or Both)	Lung Surgery	TUR PROSTATE
CYSTOSCOPY	Lymphatic Node Dissection	Umbilical Hernia
CYSTO-TUR FULGURATION	Lysis Adhesions	URETEROSCOPY
Delivery's (Vaginal or C-Section)	Mastectomy	VARICOCELECTOMY
Ear Surgery (L or R or Both)	Mastoid Surgery	VASECTOMY
EGD	MEATOTOMY	Vein Stripping
Epididymectomy	Nasal Surgery	Ventral Hernia Repair
ESWL / KIDNEY STONE LITHOTRIPSY		

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 your 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 be 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