Shlomi Albert, M.D., Inc.
11160 Warner Avenue, Suite 423
Fountain Valley, CA 92708
Phone: (714)549-3333 Fax: (714)549-3334

Date _____

Patient _____
Last Name First Name Middle Initial

Responsible Party (if minor) _____ Relationship _____

Sex: M or F Birth Date _____ Marital Status: S M W D Other _____

Social Security # _____ License Number _____ State _____

Home Phone (____)_____ Cell (____)_____

Street Address _____

City _____ State _____ Zip Code _____

Email Address: _____

Race: _____ (Optional) Preferred Language _____

Primary Care Physician _____ Phone Number (____)_____

Referring Physician _____ Phone Number (____)_____

Emergency Contact (Someone with a different number) _____

Phone Number (____)_____ Relationship _____

Pharmacy Name _____ Phone Number _____

Address _____

Employer _____ Phone Number (____)_____

Occupation _____

Primary Insurance _____ Member Number _____

Secondary Insurance _____ Member Number_____

Insurance Assignment and Release

I certify I have coverage with the insurance(s) mentioned above. I understand that if my insurance benefits and/or eligibility are not approved by my health plan (HMO or PPO) then I am financially responsible and agree to pay for all charges related to services provided to the patient.

The above-named facility may use my health care information and may disclose such information to the above-name Insurance Company(ies) and for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Patient Signature _____

Parent or Guardian's Signature (if minor)_____

Shlomi Albert, M.D., INC.

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which urology related health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings. **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature	Date	Physician Signature

Shlomi Albert, MD, Inc.
11160 Warner Avenue Suite 423, Fountain Valley CA 92708, Phone: (714) 549 - 3333 Fax: (714) 549 - 3334

Name:_____ DOB: _____ M ☐ F ☐ Today's Date:_____

Primary Care Doctor: _____ Referring Doctor: _____

Past Medical History (Check any Illnesses you have had in the past)

Check this box if none apply ☐

Condition		Condition	
Anemia	☐	Heart Attack (MI)	☐
Arthritis	☐	Hepatitis	☐
Atrial Fibrillation	☐	High Blood Pressure	☐
Breast Cancer	☐	HIV/ AIDs	☐
Colon Cancer	☐	Hypothyroidism	☐
Coronary artery disease	☐	Hyperthyroidism	☐
COPD	☐	Hypercholesterolemia	☐
Chest Pain (Angina)	☐	Irritable Bowel Disease	☐
Crohn's Disease	☐	Leukemia	☐
Depression	☐	Migraines	☐
Diabetes	☐	Osteoporosis	☐
Diverticulosis	☐	Seizures	☐
Emphysema	☐	Skin Cancer	☐
Glaucoma	☐	Stroke / CVA	☐
Gout	☐		

Other _____

_____

Past Urologic History (Check any Illnesses you have had in the past.)

Check this box if none apply ☐

Bladder Cancer	☐	Prostate Cancer (male)	☐
Blood in Urine	☐	Prostatitis (male)	☐
Epididymitis (male)	☐	Renal Insufficiency/ Failure	☐
Enlarged Prostate –BPH (male)	☐	Sexually Transmitted Infections	☐
Impotence (male)	☐	Testicular Cancer	☐
Kidney Cancer	☐	Urinary Incontinence	☐
Kidney Cyst	☐	Urinary Tract Infections (UTI)	☐
Kidney Stones	☐	Urethral Stricture	☐
Penile Cancer	☐		

Other _____

_____

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Past Surgical History (Check any surgeries you have had in the past.)

Check this box none apply ☐

Angioplasty	☐	Prostate Microwave Surgery –TUMT (male)	☐
Appendectomy	☐	Prostate Resection-TURP (male)	☐
AV Fistula	☐	Radiation for Prostate Cancer –XRT (male)	☐
Back Surgery	☐	Radical prostatectomy - RRP (male)	☐
C-Section (female)	☐	Removal of Bladder - Cystectomy	☐
Cardiac Bypass	☐	Removal of Kidney - Nephrectomy	☐
Colon Resection	☐	Resection of Bladder Tumor -TURBT	☐
Gall Bladder Removal	☐	Removal of testicle - Orchiectomy (male)	☐
Gastric Bypass	☐	Small Bowel Resection	☐
Hernia Repair	☐	Tonsillectomy	☐
Hydrocelectomy (male)	☐	Urinary Stone Surgery	☐
Hysterectomy (female)	☐	- ESWL	☐
Insicion of Urethral Stricture	☐	- Laser Lithotripsy	☐
Orthopedic Surgery	☐	- Open Stone Surgery	☐
Prostate Resection - TURP/PVP (male)	☐	Vasectomy (male)	☐

Other _____

_____

Obstetric History (Female)

Total Number of Pregnancies: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ _____
Number of children given birth: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ _____
Abortions: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ _____

Current Medications (Please list all medications and dosage.)

Check this box if not on any medication ☐

Medication	Strength	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Known Allergies? Yes ☐ No Known Allergies ☐

☐	Penicillin	☐	Codeine
☐	Sulfa	☐	Morphine
☐	Cephalosporins	☐	Demoral
☐	Nitrofurantoin	☐	Iodine
☐	Ciprofloxacin	☐	Shell Fish
☐	Levofloxacin	☐	Latex
☐	Tetracycline	☐	Peanuts

Other Allergies:

Social History

Do you smoke? Yes ☐ ____ pack(s) /day for _____ year(s)

No ☐

Quit ☐ Smoked for _____year(s)

Do you drink? Yes (Social ☐ Moderate ☐ Heavy ☐) No ☐ Quit ☐

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Occupation: _____

Family History (Check any illnesses present in your immediate family.)

Check this box if none apply ☐

Condition	Father	Mother	Brother	Sister
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐
Kidney Failure	☐	☐	☐	☐
Prostate Cancer (male)	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐

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Do you currently have any problems related to the following? Check applicable box if yes.

Constitutional Symptoms		**Cardiovascular**		**Integumentary (Skin)**	
Fever	☐	Chest Pain	☐	Skin Rash	☐
Chills	☐	Elevated Blood Pressure	☐	Persistent Itch	☐
Weight Loss	☐	Palpitations	☐	Boils	☐
Night Sweats	☐	Ankle Swelling	☐	Skin Cancer	☐
HEENT		**Genitourinary**		**Hematologic/ Lymphatic**	
Glaucoma	☐	Testicular pain (male)	☐	Swollen Glands	☐
Cataracts	☐	Testicular mass (male)	☐	Bleeding Tendency	☐
Headaches	☐	Kidney stones	☐	Abnormal Bruising	☐
Sinus Problems	☐	Infertility (male)	☐	Anemia	☐
Sore Throat	☐	Flank pain	☐	Varicose veins	☐
Ear Infection	☐	Poor Erections (male)	☐		
		Blood in Semen (male)	☐	**Endocrine**	
		Blood in Urine	☐	Excessive Thirst	☐
		Painful Urination	☐	Hot/Cold Intolerance	☐
		Frequent Urination	☐	Hot Flashes	☐
		Incontinence	☐	Thyroid Disease	☐
Gastrointestinal		**Neurological**		**Psychiatric**	
Abdominal Pain	☐	Tremors	☐	Depression	☐
Nausea	☐	Seizures	☐	Anxiety	☐
Vomiting	☐	Dizziness	☐	Suicide	☐
Diarrhea	☐				
Blood in Stool	☐				
Constipation	☐				
Loss of Appetite	☐				
Respiratory		**Musculoskeletal**		**Gynecologic (female)**	
Shortness of Breath	☐	Back Pain	☐	Irregular Periods	☐
Cough	☐	Joint Pain	☐	Vaginal Pain	☐
Wheezing	☐	Bone Pain	☐	Pelvic Pain	☐
Asthma	☐	Neck Pain	☐	Menopause	☐
Blood in Sputum	☐	Arthritis	☐		

Other :

Shlomi Albert, M.D., Inc.

Mayela Castrejon, Privacy Officer

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

☐ Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por e-mail a:

_____

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

_____

_____

Shlomi Albert, MD., Inc.

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****

SECTION A: The Individual (or the Individual's Personal Representative) confirming the authorization.
I authorize the use and/or disclosure of my protected health information as described in Section B below. I understand that this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

SECTION B: The use and/or disclosure being authorized.
Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed:

_____

_____

I hereby authorize, Shlomi Albert, M.D., Inc. to release the above mentioned health information to:
Entities Authorized to Receive and Use: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing us to disclose and/or let use the protected health information described above:

_____	_____	_____
(Name)	(Relationship)	(Phone Number)
_____	_____	_____
(Name)	(Relationship)	(Phone Number)
_____	_____	_____
(Name)	(Relationship)	(Phone Number)

SECTION C: Expiration and Revocation.
Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Shlomi Albert, M.D., Inc.
Telephone: (714) 549-3333 Fax: (714) 549-3334
Address: 11160 Warner Avenue, Suite 423, Fountain Valley, CA 92708

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature:_____ Date:_____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Representative's Name: _____ Relationship to Individual:_____

Patient Account #:_____ Refuse to Sign Authorization ( ) Date:_____