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 (____)_____

Employment Status: Employed (FT) or (PT) Retired Disabled Unemployed

Employer _____ Phone Number (____)_____

Occupation _____ Student Status: FT - PT - None

In case of an emergency, who should be notified? _____

Phone Number (____)_____ Relationship _____

Primary Insurance _____ Member Number _____

Secondary Insurance _____ Member Number _____

Pharmacy Name _____ Phone Number _____

Address_____

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)_____

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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
- ☐ Sulfa
- ☐ Cephalosporins
- ☐ Nitrofurantoin
- ☐ Ciprofloxacin
- ☐ Levofloxacin
- ☐ Tetracycline
- ☐ Codeine
- ☐ Morphine
- ☐ Demoral
- ☐ Iodine
- ☐ Shell Fish
- ☐ Latex
- ☐ 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 :

NOTICE OF PRIVACY PRACTICES

Shlomi Albert, M.D., Inc.

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

We are required by applicable federal and state law, including the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes.

We may use and disclose medical information about you for the following purposes: Treatment, Payment and Health Care Operations:

- Treatment: We may use your medical information to treat you or disclose your medical information to a physician or other health care provider providing treatment to you.
- Payment: We may use and disclose your medical information to obtain payment for services we provide you.
- Health Care Operations: We may use and disclose your medical information in connection with the normal course of operating our practice. Health care operations may also include quality assessment activities, performance evaluations, conducting training programs, accreditation, and certification, licensing or credentialing activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. Any other uses and disclosures of your medical information will only be made with your written authorization or in response to legal requirements such as disaster relief, court orders, suspected abuse, neglect, or domestic violence, or in certain instances affecting national security.

You have the following rights with respect to your protected health information which you may exercise by written request using the contact information at the end of this notice:

- The right to request additional restrictions on the 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 which must be in writing.
- The right to inspect and copy your protected health information.
- The right to request amendments to your protected health information.
- The right to receive an accounting of disclosures of your personal health information for other than treatment, payment, health care operations or pursuant to other authorized disclosures as stated above.
- The right to obtain a copy of this notice

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we have made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services to the address listed at the end of this notice.

I acknowledge that I have received a copy of the Notice of Privacy Practices. Date: _____

Name: _____ Signature: _____

Name of Personal Representative: _____ Signature: _____

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

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

U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, DC 20202 – (877) 696-6675

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:_____

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I, undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient.

RECORDS TO BE RELEASED FROM:

_____
(Doctor, Hospital, Clinic, ect.)

_____
(Address)

_____
(City, State, Zip Code)

_____
(Telephone Number) (Fax Number)

RECORDS TO BE RELEASED TO:

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

INFORMATION TO BE RELEASED OR ACCESSED:

( ) History & Physical ( ) Consultation Report ( ) Emergency Room Record
( ) Operative Reports ( ) Discharge Summary ( ) Laboratory Reports
( ) Pathology Reports ( ) X-Ray Reports ( ) Entire Medical Record
( ) Other _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected. I understand that the specific information to be released may include, but is not limited to: history, diagnosis, and or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of the specific data. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of the information has been made prior to receipt of the revocation. This authorization expires one year from the date of signature unless I specifically request or otherwise revoke it. I understand I may be charged a fee for retrieval/processing and copying of my medical records.

I HAVE READ AND UNDERSTAND THIS CONSENT AND I HAVE SIGNED IT VOLUNTARILY AND OF MY OWN FREE WILL.

_____ _____
(Signature of Patient) (Signature of Parent/Legal Representative

_____ _____
(Date) (Witness)