UROLOGY OF MOUNT DORA
Jack Cassell, M.D., P.A.

717 North Donnelly Street
Mount Dora, FL 32757
(352) 383-3773
Fax (352) 383-4434

Specializing in Minimally Invasive Procedures

Patient Information			
Patient		Address	
Date of Birth			
Age		City	
Gender		State	
Social Security #		Zip	
Height		Marital Status	
Weight		Home Phone	
Referred By		Work Phone	
Email		Cell Phone	
Primary Physician			
Primary Physician		Office Phone	
Insurance Information (including Medicare and/or Medicaid)			
Primary Insurance		Secondary Insurance	
Policy #		Policy #	
Group #		Group #	
Insured's Name		Insured's Name	
Insured's DOB		Insured's DOB	
Pharmacy Information and Emergency Contact Information			
Preferred Pharmacy		Emergency Contact	
Address/Intersection		Relationship	
City, State, Zip		Primary Number	
		Secondary Number	

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Name _____ Date of Birth _____

Today's Date _____

PLEASE TELL US ABOUT YOUR SURGICAL HISTORY ☐ **NO SURGICAL HISTORY**

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

WOMEN PLEASE COMPLETE THE FOLLOWING

Number of pregnancies _____ Number of Cesarian sections _____

Number of vaginal deliveries _____ Are you currently pregnant? ☐ Yes ☐ No

Date of last menstrual period _____

EVERYONE PLEASE COMPLETE THE FOLLOWING

FAMILY HISTORY Please check all that apply ABOUT BLOOD RELATIVES ONLY

- ☐ Blood Disease
- ☐ BPH (Prostate enlargement)
- ☐ Cancer Type 1. _____ 2. _____
  Relation 1. _____ 2. _____
- ☐ Cerebrovascular accident (stroke)
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ Eczema
- ☐ Gout
- ☐ Hearing impairment
- ☐ Hyperlipidemia
- ☐ Hypertension (high blood pressure)
- ☐ Inflammatory bowel disease
- ☐ Migraines
- ☐ Renal failure
- ☐ Seizure disorder
- ☐ Thyroid disorder
- ☐ Urinary tract infections
- ☐ Urolithiasis (urinary tract stones)

Other: _____

SOCIAL HISTORY Current marital status ☐ S ☐ M ☐ W ☐ D

Occupation _____

Tobacco ☐ Yes ☐ No

- ☐ Cigarettes ☐ Former
- ☐ Cigar ☐ Pipe
- ☐ Chewing ☐ Smokeless

Packs/day _____

How many years? _____

Tried to quit? ☐ Yes ☐ No

Year you quit _____

Passive smoke exposure? ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No

- ☐ Beer ☐ Wine ☐ Liquor
- ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially ☐ Rarely

Amount: _____

Last Drink: _____

Caffeine ☐ Yes ☐ No Caffeine per day_____

- ☐ Chocolate ☐ Tablets
- ☐ Coffee
- ☐ Soda
- ☐ Tea

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Do you take prescription blood thinners?	☐ yes	☐ no
Do you take aspirin or anti-inflammatory medicines every day?	☐ yes	☐ no
Do you have heart valve problems?	☐ yes	☐ no
Have you had a joint or heart valve replacement?	☐ yes	☐ no
Are you allergic to latex? If yes, reaction: _____	☐ yes	☐ no
Are you allergic to intravenous contrast (dye)?	☐ yes	☐ no

What is (are) the reason(s) for your visit today? _____

_____

PLEASE LIST YOUR MEDICATION ALLERGIES | REACTION | ☐ NO ALLERGIES THAT I KNOW OF

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Other Allergies _____

PLEASE LIST YOUR MEDICATIONS, PRESCRIPTION, OVER-THE-COUNTER, AND HERBAL ☐ I TAKE NO MEDICATIONS

For each medication, please tell us the dose and how often you take it.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PLEASE TELL US ABOUT YOUR MEDICAL HISTORY ☐ NO SIGNIFICANT MEDICAL HISTORY

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Other Allergies _____

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Today's Date _____

PLEASE CHECK ALL THAT APPLY TODAY

☐ NONE

URINARY (GENITOURINARY)

- ☐ Back pain
- ☐ Change in urine color
- ☐ Cloudy urine
- ☐ Decreased stream
- ☐ Painful urination (dysuria)
- ☐ Flank pain
- ☐ Frequency
- ☐ Groin mass
- ☐ Blood in urine (hematuria)
- ☐ Hesitancy
- ☐ Incontinence
- ☐ Low urine output
- ☐ Get up at night to urinate (nocturia)
- ☐ Passing stone(s)
- ☐ Excessive urination (polyuria)
- ☐ Urgency

CARDIOVASCULAR

- ☐ Chest Pain (cardiac)
- ☐ Shortness of breath (dyspnea)
- ☐ Lower leg swelling (edema)
- ☐ Shortness of breath at night (nocturnal dyspnea)

REPRODUCTIVE MALE

- ☐ Not applicable
- ☐ Penile discharge
- ☐ Blood in ejaculate (hematospermia)
- ☐ Scrotum/testicular pain
- ☐ Scrotum/testicular mass
- ☐ History of hydrocele
- ☐ Genital herpes
- ☐ Infertility
- ☐ Decreased libido
- ☐ Erection problems

CONSTITUTIONAL

- ☐ Activity change
- ☐ Decreased appetite
- ☐ Fever
- ☐ Fatigue
- ☐ Insomnia
- ☐ Irritability
- ☐ Malaise
- ☐ Night Sweats
- ☐ Recent weight gain
- ☐ Recent weight loss

REPRODUCTIVE FEMALE

- ☐ Not applicable
- ☐ Pre-menopausal
- ☐ Peri-menopausal
- ☐ Menopausal

Date of last menses

_____

- ☐ Hormone replacement
- ☐ Uterine fibroids
- ☐ History of abnormal PAP
- ☐ Ovarian cyst(s)
- ☐ Unusual vaginal discharge

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Blood in stool
- ☐ Indigestion/Heartburn
- ☐ Jaundice
- ☐ Nausea
- ☐ Reflux

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ELIGIBILITY GUARANTEE FORM

I hereby certify that I am eligible for the health insurance company under the subscriber listed in my registry sheet. I also certify that I have chosen Jack Cassell, M.D. to provide healthcare services. I understand that, were the aforementioned statement not true of if I were not eligible under the terms if the Subscriber's Medical and Hospital Agreement, I'd be responsible for any and every charge for the services rendered. Also, if the aforementioned were not true, I agree to pay completely all the services rendered within thirty days after receiving an invoice from said medical group or doctor.

_____

Patient's Signature Date

ASSIGNMENT OF BENEFITS

I hereby authorize that the benefit payment be made directly to Jack Cassell, M.D. for services provided to me and I also declare that I assume responsibility for the payment of charges not covered in the allocation. I authorize the refund of payments in excess of insurance benefits, when the coverage is subject to benefit this allocation. I authorize the refund of payments in excess of insurance benefits, when the coverage is subject to benefit coordination in the event of payment default. I hereby pledge to pay every collection cost, including reasonable legal fees.

Patient's Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services received or benefits for related services.

Patient's Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE

HIPPA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our notice of privacy practice and that you acknowledge with your signature that you have received the brochure.

Initials: _____

You may share health information about the patient's condition with:(List here the names of individuals, family members, or other relations to whom you wish to grant authorization to share medical information.)

Patient's Signature: _____ Date: _____