Bruha Urology
702 N Alexander St
Plant City, FL 33563

Phone: 813-722-URIN
Fax: 813-754-4700
Web: BruhaUrology.com

New Patient Information

Patient Information: Today's Date: _____

First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Gender: ☐ Male ☐ Female ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐ Other

Address: _____ City: _____ State: ____ Zip _____

Phone Number (Cell): _____ Phone Number (Home/Work): _____

SSN: _____ Email Address: _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Emergency Contact: _____ Phone: _____

Relationship to Emergency Contact: _____

Insurance Information

Primary Insurance:

Insurance Company: _____

Policy Number: _____ Group Number: _____

Policyholder's Name: _____

Policyholder's Date of Birth (MM/DD/YYYY): _____

Policyholder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Secondary Insurance (*if applicable*):

Insurance Company: _____

Policy Number: _____ Group Number: _____

Policyholder's Name: _____

Policyholder's Date of Birth (MM/DD/YYYY): _____

Policyholder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Primary Physician and Pharmacy

Primary Care Physician Information:

Physician Name: _____ Practice Name: _____

Phone Number: _____ Fax Number: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Address: _____ Pharmacy Fax: _____

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Medical History

Your Weight: _____ Height: _____

When was your last EKG? _____ Where: _____

When was your last chest X-ray: _____ Where: _____

Reason for your today's visit: _____

_____

Current Medications (*including dosages and frequency*):

Medication 1: _____ Medication 2: _____

Medication 3: _____ Medication 4: _____

Medication 5: _____ Medication 6: _____

Allergies (*medications, food, or environmental*):

Allergy 1: _____

Allergy 2: _____

Allergy 3: _____

Medical Conditions (*check all that apply*): If no medical problems, check here ☐

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ COPD/Emphysema
- ☐ Cancer (Specify type): _____
- ☐ Chronic Urinary Tract Infections
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Erectile Dysfunction
- ☐ Glaucoma
- ☐ HIV
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Incontinence
- ☐ Infectious Mono
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Plasma Transfusion
- ☐ Prostate Issues
- ☐ Renal Disease
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Urinary Tract Infections (UTIs)
- ☐ Other: Please Specify: _____

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Urological History

1. Have you ever been diagnosed with any urological condition? ☐ Yes ☐ No

   If yes, please specify: _____

2. Have you experienced any of the following? (Check all that apply)

   ☐ Painful urination

   ☐ Blood in urine

   ☐ Frequent urination

   ☐ Urinary incontinence

   ☐ Erectile dysfunction

   ☐ Prostate enlargement or issues

   ☐ Urinary tract infections

   ☐ Kidney stones

   ☐ Other urologic issues (Please specify): _____

3. Do you have a history of:

   ☐ Kidney Disease

   ☐ Bladder Cancer

   ☐ Prostate Cancer

   ☐ Testicular Issues

   ☐ Sexually Transmitted Infections (STIs)

   ☐ Other: _____

Past Surgeries (*if any*):

General Surgery
- ☐ Appendix
- ☐ Abdominal Hernia
- ☐ Bowel
- ☐ Gall Bladder
- ☐ Groin Hernia
- ☐ Hemorrhoid
- ☐ Incisional Surgery
- ☐ Spleen
- ☐ Stomach
- ☐ Tonsil & Adenoid

Lung Surgery
- ☐ Benign
- ☐ Cancer

Heart Surgery
- ☐ Bypass Graft
- ☐ Valve
- ☐ Vascular Surgery

Urologic Surgery
- ☐ Trim of Prostate Gland
- ☐ Urethral Stricture
- ☐ Testicular Surgery
- ☐ Vasectomy
- ☐ Testicular Removal
- ☐ Circumcision
- ☐ Removal of Penile Lesion
- ☐ Penile Lesion

Female Surgery
- ☐ Ovaries
- ☐ Uterus
- ☐ Other

Other Surgery
- ☐ Ear Surgery
- ☐ Eye Surgery
- ☐ Glaucoma
- ☐ Nose Surgery

Kidney Surgery
- ☐ Entire Removal of Kidney
- ☐ Partial Removal of Kidney
- ☐ Open Removal of Stone

Orthopedic Surgery
- ☐ Artificial Hip/Knee
- ☐ Back Surgery
- ☐ Disc Surgery
- ☐ Knee Surgery

Bladder Surgery
- ☐ Abdominal/Vaginal
- ☐ Entire Removal of Bladder
- ☐ Lifting of Bladder
- ☐ Partial Removal of Bladder
- ☐ Removal of Bladder Stone
- ☐ Removal of Bladder Tumor

Other: _____

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Lifestyle and Social History

Smoking History:

Do you smoke? ☐ Yes ☐ No ☐ Former smoker ☐ Exposure secondhand smoke

If yes, how many cigarettes per day? _____

If quit, how long ago? _____

Drug Use:

Do you use recreational or street drugs? ☐ Yes ☐ No

If yes, please list: _____

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No. If yes, how many drinks per week? _____

Caffeine Use:

How many cups of coffee you drink in a day? ☐ None ☐ 1-2 cups ☐ more than 3 cups

Exercise:

How often do you exercise? _____

Type of exercise: _____

Diet:

Do you follow a specific diet? ☐ Yes ☐ No

If yes, please specify: _____

Review of Systems

Please indicate if you have had any of the following symptoms in the past 6 months:

☐ Unexplained weight loss

☐ Pain or discomfort in the abdomen or pelvis

☐ Blood in stool

☐ Frequent or painful urination

☐ Nausea/Vomiting

☐ Swelling in legs or feet

☐ Difficulty urinating

☐ Back pain

☐ Sexual dysfunction

☐ Other (Please specify): _____

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Family Medical History

Please check any conditions that apply to your immediate family (parents, siblings, children):

	Father	Mother	Brother	Sister	PGF*	PGM*	MGF*	MGM*
Bladder Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Renal Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Testicular Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐
Urinary Stones	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer type:	☐	☐	☐	☐	☐	☐	☐	☐
Other Family Hx:	☐	☐	☐	☐	☐	☐	☐	☐

Check here if family history is not available ☐

* PGF – Paternal grandfather (Biological father's father)
* PGM – Paternal grandmother (Biological father's mother)
* MGF – Maternal grandfather (Biological mother's father)
* MGM – Maternal grandmother (Biological mother's mother)

Additional Person(s) Authorized To Use or Disclosure

We at Bruha Urology Associates value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouse, parents, children or any significant others) without your written consent. If you want anyone other that your referring physician to have access to your medical information, please list their name, relationship and phone number below.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

☐ This will never expire ☐ This will expire on _____

Patient Name: _____ **Date:** _____

Patient Signature: _____

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Financial Responsibility & Release of Information

I hereby authorize, request and direct any and all assigned insurance companies to pay directly to Bruha Urology Associates, LLC, or any treating physician the amount due pending claims for these benefits under the respective policies. I agree that should the amount be insufficient to cover the entire expense; I will be responsible for payment of the entire bill.

Denial of Payment Authorization: Bruha Urology Associates, LLC will make every effort to obtain payment/authorization/preauthorization for all managed care contractual agreements. If, however, a denial is received, the patient/guarantor/will be responsible for all incurred charges and penalties.

Consent and Acknowledgment

I, the undersigned, give my consent for the medical staff at this urology office to treat me as necessary. I understand that the information provided is accurate to the best of my knowledge, and I agree to notify the office of any changes to my medical history, contact information, or insurance.

Patient Full Name: _____

Patient Signature: _____

Date: _____

HIPAA Acknowledgment

I acknowledge that I have received the Notice of Privacy Practices provided by this urology office, which outlines how my health information will be used and protected under HIPAA regulations.

Patient Full Name: _____

Patient Signature: _____

Date: _____

Additional Notes/Requests

Any additional information you'd like to share with your urologist?

_____

_____

_____

Patient Name: _____ **Date: _____**

Patient Signature: _____

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Authorization for Use and Disclosure of Protected Health Information

I hereby authorize _____ to use and/or disclose my protected health information as described below to the entity listed below for purposes of treatment and evaluation.

Name: Bruha Urology Associates
Address: 702 N. Alexander St., Plant City, FL 33563
Phone: 813-722-8746, Fax: 813-754-7400

I understand that this authorization is voluntary, and I may refuse to sign this authorization without affecting my healthcare or the payment for my healthcare. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law, see 45 CFR @ 164524), I may revoke this authorization at any time by Bruha Urology Associates in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy. If the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, the released information may no longer be protected by federal privacy regulations Bruha Urology Associates agrees to maintain the confidentially of your protected health information, however, federal law (HIPAA) requires you be advised that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected by HIPAA rules. In addition, I authorize that this may include health information relating to HIV/AIDS infection or Drug/Alcohol abuse.

Patient Initials: _____

Please Fax the following information:

☐ MRI/X-Ray/Radiology Reports ☐ Office Visits

☐ Initial History and Physical ☐ Lab Reports

☐ Other: _____

_____

Patient Printed Name _____ Patient Date of Birth: _____

Name Patient Signature _____ Patient Phone # _____

This authorization will expire 180 days from the date of signing (Today's date) _____