Murray G. Goldberg, M.D.
R. Neill Borland, M.D.
Stephanie Cindric, APRN

TGH Tampa General Hospital | UROLOGY GROUP OF FLORIDA

3399 PGA Blvd, Suite 230 Palm Beach Gardens, FL 33401

NAME	SEX AT BIRTH M☐ F☐	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

FLORIDA ADDRESS	CITY AND STATE	ZIP CODE	TIME SPENT AT ADDRESS

NORTHERN ADDRESS	CITY AND STATE	TIME SPENT AT ADDRESS

HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

SPOUSE'S/PARTNERS NAME	NUMBER OF CHILDREN AND AGES	MARITAL STATUS S	M	DP	W	D

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE NUMBER	BUSINESS PHONE NO.

PRIMARY CARE PROVIDER	PHONE NUMBER	FAX NUMBER

PHARMACY ADDRESS AND PHONE NUMBER	REFERRED BY

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE	POLICY HOLDER

GOVERNMENT-MANDATED QUESTIONS:

RACE ☐ Caucasian ☐ Afro-American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander Other _____
PRIMARY LANGUAGE ☐ English ☐ Spanish ☐ Other _____ ☐ Declined

ETHNICITY (CHECK APPROPRIATE)
☐ NO, Not Hispanic, Latino, or Spanish Origin ☐ YES, Mexican, Mexican-American or Chicano Origin
☐ YES, Puerto Rican Origin ☐ YES, another Hispanic, Latino or Spanish Origin ☐ Declined

DATE:

I certify that all the above information is accurate. I hereby authorize the release of any information necessary to process my claims. I hereby authorize the release of my medical information to my referring healthcare provider as well as to those I may be referred to for consultation and/or treatment. Payment of any government benefits may be made either to me or to the party who claims the assignment.

I authorize the payment of medical benefits directly to my physician. I am financially responsible for any unpaid balance due. I agree to pay any deductibles, co-insurance, and co-pays. I understand that I am financially responsible for any charges not covered by my insurance and if I fail to give updated current information and the claim is denied, I will be responsible for the entire balance.

Missing your appointment or failure to give us 24 hours' notice of canceling an appointment creates an undue burden and increases the cost of care to other patients. Should you miss your appointment, you will be billed a $50.00 missed appointment fee. If you miss 3 appointments, you will be dismissed from the practice.

To be as accurate as possible, we update personal demographics, insurance information, medical history, and medications at each visit. If you have tests as part of your appointment, we promise to get the results to you as quickly as possible. Some tests/labs are performed by outside parties, in such cases they will bill you separately.

We accept cash, check or credit card. We send 3 statements, after which delinquent accounts are turned over to a collection agency. You understand and agree that if we are forced to send your account to collection, a fee of 50% of the unpaid balance will be added. This amount shall be in addition to any other cost incurred directly or indirectly to collect amounts owed under this agreement.

Signed _____ Date _____

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Neill Borland, MD
Stephanie Cindric, APRN

History and Intake Form

Patient Name: _____ Date of Birth: _____

Primary and/or Referring Physician: _____

Pharmacy Location and Contact: _____

Main Reason for your visit: _____

Social History:

Do you smoke? YES NO If "YES", how many packs per day? _____

Have you previously smoked? YES NO How many packs per day did you smoke? _____
When did you stop? _____ In years, how long did you smoke? _____

Do you drink alcoholic beverages? YES NO Occasionally
If "YES", how many daily? _____

Past Medical History: (Please check "YES" for all that apply)

	YES	NO		YES	NO		YES	NO
Anxiety	☐	☐	Coronary Artery Disease	☐	☐	High Cholesterol	☐	☐
Arthritis	☐	☐	Depression	☐	☐	Hyperthyroidism	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	Hypothyroidism	☐	☐
Atrial Fibrillation	☐	☐	End Stage Renal Disease	☐	☐	Leukemia	☐	☐
Bone Marrow Transplant	☐	☐	GERD	☐	☐	Lung Cancer	☐	☐
BPH	☐	☐	Hearing Loss	☐	☐	Lymphoma	☐	☐
Breast Cancer	☐	☐	Heart Attack	☐	☐	Prostate Cancer	☐	☐
Colon Cancer	☐	☐	Hepatitis	☐	☐	Radiation Treatment	☐	☐
COPD	☐	☐	High Blood Pressure	☐	☐	Seizure	☐	☐
			HIV/AIDS	☐	☐	Stroke	☐	☐

Other: _____

Please list all surgeries you have had and when they occurred:

☐ No Surgeries

☐ Bladder Surgery: _____
☐ Kidney Surgery: _____
☐ Joint Replacement: _____
☐ Cardiovascular: _____
☐ Prostate Surgery/Biopsy: _____
☐ Scrotal Surgery: _____

Please list all other surgeries, if not listed previously:

_____

_____

_____

_____

_____

Urologic Disease History: (Please check "YES" for all that apply)

	YES	NO		YES	NO		YES	NO
Blood in Urine	☐	☐	Hydronephrosis	☐	☐	Renal Tubular Acidosis	☐	☐
Cancer (Bladder)	☐	☐	Infertility	☐	☐	Sexual Dysfunction	☐	☐
Cancer (Kidney)	☐	☐	Stones (Urolithiasis)	☐	☐	STD/STI	☐	☐
Cancer (Penile)	☐	☐	Neurogenic Bladder	☐	☐	Undescended Testis	☐	☐
Cancer (Prostate)	☐	☐	Painful Urination (Dysuria)	☐	☐	Urethral Stricture	☐	☐
Cancer (Testicular)	☐	☐	Polycystic Kidney Disease	☐	☐	Urinary Incontinence	☐	☐
Elevated PSA	☐	☐	Priapism	☐	☐	Urinary Retention	☐	☐
Genitourinary Trauma	☐	☐	Prostatitis	☐	☐	Urinary Tract Infection	☐	☐
			Renal Insufficiency	☐	☐	Vesicoureteral Reflux	☐	☐

Other: _____

Family History: (Please check "YES" for all that apply and indicate Family Member)

	YES	NO	
Kidney Cancer	☐	☐	Who: _____
Bladder Cancer	☐	☐	Who: _____
Prostate Cancer	☐	☐	Who: _____
Genital Cancer	☐	☐	Who: _____
Kidney Stones	☐	☐	Who: _____
Kidney Disorders	☐	☐	Who: _____
Bleeding Disorders	☐	☐	Who: _____
Heart Disease	☐	☐	Who: _____

Please list any allergies and type of reaction: ☐ No Known Drug Allergies

Allergies	Reaction

Review of Systems: **(Please check all POSITIVE complaints.)** □ No Positive Complaints

Constitutional: □ Chills □ Fever □ Weight loss

Eyes: □ Blurred Vision □ Eye Pain □ Worsening Eyes

Allergies: □ Drug □ Food □ Seasonal

Neurological: □ Dizzy □ Headache □ Seizures

Endocrine: □ Thirst □ Tired □ Hot/Cold

GI: □ Heartburn □ Diarrhea □ Constipation

Kidney Disease: □ Renal Failure □ Transplant

Cardio: □ Chest Pains □ Swollen ankles □ High Blood Pressure

Skin: □ Rash □ Lesions □ Psoriasis

Musculoskeletal: □ Arthritis □ Cramps □ Gout

ENT: □ Sore Throat □ Ear Infections □ Sinus Problems

Respiratory: □Asthma □ Shortness of Breath □ Cough

Hematologic: □Anemia □ Easy Bleeding □ Swollen Glands

Psychologic: □ Anxiety □ Depression □ Suicidal Thoughts

Other Conditions: _____

Please select the most appropriate answer to the following questions.

	Never	Rarely	Sometimes	Half the Time	Often	Always
How often do you have the temptation of not emptying your bladder completely?	☐	☐	☐	☐	☐	☐
How often do you have to urinate again within 2 hours of urinating?	☐	☐	☐	☐	☐	☐
How often have you stopped and started several times during urination?	☐	☐	☐	☐	☐	☐
How often have you had difficulty in postponing urination?	☐	☐	☐	☐	☐	☐
How often is the urinary stream weak?	☐	☐	☐	☐	☐	☐
How often do you strain to begin to urinate?	☐	☐	☐	☐	☐	☐
How many times do you get up at night to urinate?	□ 0	□ 1	□ 2	□ 3	□ 4	□ 5+
Do you have burning pain upon urination? ☐ YES ☐ NO						
Do you have leakage of urine? ☐ YES ☐ NO						
Do you see blood in your urine? ☐ YES ☐ NO						
How would you feel if you had to live with your urinary condition the way it is now, no better and no worse, for the rest of your life? ☐ Delighted ☐Pleased ☐Mostly Satisfied ☐Mixed ☐Unhappy ☐Terrible						

Please, turn this page over to continue.

Please list any medications and complete the following table to the best of your abilities:
(If you need more space, we will gladly provide you with another sheet of paper.)

□ No Medications

Medication Name	Dose	Frequency	Route (i.e., Oral, topical, injection, etc.)

I hereby attest that the information provided on this form is accurate and truthful.

_____
Patient/Guardian Signature

_____
Date

_____
Patient/Guardian Printed Name

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MURRAY G. GOLDBERG, M.D.
R. NEILL BORLAND, M.D.
STEPHANIE CINDRIC, APRN

3399 PGA Blvd, Suite 230
Palm Beach Gardens, FL 33401

Dear Patient:

As part of our EHR (Electronic Health Record) Program, we are testing the ability to provide our patients with a clinical summary of your last visit with your Physician.

If you wish to receive a clinical summary, please contact the office where you were seen. The office will print a copy and you can pick up from the office within 3 business days following your appointment.

Please review the clinical summary. We believe the summary will provide you with relevant information from your visit. If you notice any major discrepancies, you may send a written request for changes to the office in which you were seen. If you prefer, you may bring the changes to your next visit.

_____
Patient Name (PRINT)

_____
Patient Signature

_____
Date

Thank you,
Urology Group of Florida

TGH Tampa General Hospital | UROLOGY GROUP OF FLORIDA

Murray Goldberg, MD
Neill Borland,
MD Stephanie Cindric, APRN

To the patient,

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment.

I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of
- Healthcare professionals.

I understand that I have the right to:

- To object the use of my health information for directory purposes.
- To request restrictions as to how health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

In general, the HIPAA privacy rules give individuals right to request a restriction on uses or disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to an address other than your home address.

The physicians and staff of Urologic Physicians and Surgeons, P.A respect your privacy and wish to make all reasonable attempts to respect your wishes regarding your confidential information. With that in mind, please indicate your preference for the areas noted below.

I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone _____
- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back number only

☐ Work Phone _____
- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back number only

☐ Other Individuals (family, friends, etc) you may speak with about
- ☐ My care of treatment
- ☐ My Bill

☐ Mobile Phone_____
- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ Ok to mail my home address
- ☐ Ok to mail my work/office address
- ☐ Ok to fax: _____

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____
Patient Name (PRINT)

_____
Date of Birth

_____
Patient Signature

_____
Date