DANIEL N. EAD MD
1216 N. University Drive, Plantation, FL 33322 PHONE: 954-472-4072

Patient Legal Name_____ Sex ☐ Male ☐ Female □ Other
Birthdate _____ Age _____ Marital Status: ☐ S ☐ M ☐ W ☐ D
Social Security # _____

How did you hear about Dr. Ead? _____

Required by the US Department of Health:

Race: ☐White ☐Black/African American ☐Asian ☐Latino ☐American Indian/Alaska Native ☐Decline
Ethnic Group: _____ or ☐Decline Preferred Language: _____
Address: _____ Apt ____ City _____ State ____ Zip _____
Preferred Phone Number: _____ May we leave messages regarding your appointment? □Y □ N
Secondary Phone number: _____
E-Mail: _____May we send information regarding your appointment □Y □ N
Primary Doctor: _____ Primary Doctor Phone: _____

EMERGENCY CONTACTS

Name: _____ Phone: ( ) _____ Relationship:_____ Can we speak to this person regarding information related to your medical condition, insurance, etc? □ YES □ NO

Name: _____ Phone: ( ) _____ Relationship:_____ Can we speak to this person regarding information related to your medical condition, insurance, etc? □ YES □ NO

If Patient Is a Minor, Please Complete the Following:

Mother's Name: _____
Employed By: _____
Phone: _____

Father's Name: _____
Employed By: _____
Phone: _____

PLEASE READ CAREFULLY

I accept and acknowledge that that I am solely responsible for knowing the providers and facilities in my insurance company's network, and what their referral policies are. I understand that any information given to me by an Employee of Daniel N Ead, MD, is based on the best of the employee's ability and does not guarantee that DANIEL N EAD MD PA is covered under your particular insurance plan nor do they have knowledge of what is covered under your plan. If I accept a referral to a provider or facility outside my insurance network, I accept and acknowledge that I am responsible for any charges not covered by my insurance company or Medicare**. I also understand that ONLY** my insurance company can determine what my financial responsibility will be, and that any financial information given to me by an employee is an **estimate** and that I may owe more money, or may be entitled to a refund.

I understand, accept, and acknowledge that **any testing performed in the office may be subject to deductibles, coinsurance and/or copays,** and that I am responsible for any additional charges my insurance company states is patient responsibility. I understand that the staff of Dr. Ead does not know in advance if this testing will be subject to additional patient financial responsibility.

Pathology Consent: I hereby authorize Dr. Daniel Ead to order any pathology testing deemed medically necessary in connection with office visits or surgeries. I also understand that **I am financially responsible for any tests not covered by my insurance.**

_____ _____ _____
Printed Name of Patient or Guardian Signature Date

NAME: _____ Date of Birth: _____/_____/_____ Age: _____

PHARMACY NAME REQUIRED_____PHARMACY PHONE REQUIRED:_____

Who is your primary care doctor? _____

WHAT BRINGS YOU IN TODAY? _____

Where is problem located? _____How long has it been going on? _____How bad on a scale of 1 to 10? _____

Are your symptoms constant or intermittent? _____What makes your symptoms better or worse? _____

Are you presently having any of the following Urological symptoms:

_____ Blood in Urine	_____ Burning on urination	_____ Frequency of Urination
_____ Leakage of Urine/incontinence	_____ Urgency	_____ Getting up at night to urinate
_____ Straining to Urinate	_____ Abdominal Pain	_____ Flank Pain
_____ Groin Pain	_____ Genital pain	_____ Fever or chills

List all medical conditions (Circle):

Diabetes-Hypertension-Cholesterol-Hypothyroidism-Coronary Artery Disease-Arthritis-Atrial Fibrillation-Stroke

Other: _____

List all prior surgeries: (Circle):
Hernia Repair – Gallbladder – Appendectomy – Cardiac Stent – Tonsillectomy – Knee surgery – Kidney stone surgery – Hip surgery – Pacemaker – Cataract – Vasectomy – Circumcision – TURP – Coronary Artery Bypass Graft – C Section - Hysterectomy
Other: _____

FAMILY HISTORY: Does anyone in your family have a history of ☐ prostate cancer, ☐ kidney cancer or ☐ bladder cancer**?**

If Yes, who? _____

MEDICATION ALLERGIES: Do you have any allergies IF YES, PLEASE LIST THEM _____

SOCIAL HISTORY Are you married? Yes / No **Do you have children?** Yes / No **How many?** _____

DO YOU SMOKE TOBACCO: □ Yes □ No **Alcohol**: □ Yes □ No Your O**ccupation**:_____

YOUR HEIGHT: _____ YOUR WEIGHT: _____

Do you have any of the following complaints today? (Please circle)

Fever	Yes___ No___	Palpitations	Yes___No___	Muscle aches	Yes___No___
Weight loss	Yes___No___	Shortness of breath	Yes___No___	Skin rash	Yes___No___
Visual changes	Yes___No___	Diarrhea	Yes___No___	Dizziness	Yes___No___
Hearing changes	Yes___No___	Constipation	Yes___No___	Headaches	Yes___No___
Sore throat	Yes___No___	Nausea/Vomiting	Yes___No___	Abnormal bleeding	Yes___No___
Chest pain	Yes___No___	Joint pain	Yes___No___	Swollen glands	Yes___No___

Office use only: HPI
_____
_____
_____
_____
_____
_____
_____
_____

FEMALE:
Office Use Only: Obese / Overweight/Normal weight
External Normal Y/N;
Cystocele Y/N
Uretheral Meatus Ample Y/N
Bimanual Exam: Mass Y/N

MALE:
Office Use Only: Obese / Overweight/Normal weight
Penis Lesion Y/N; Circumcised Y/N
Scrotum: Rash Y/N, Hydrocele Y/N Varicocele Y/N
Testis; Mass Y/N;
Epididymis Cyst Y/N
DRE: Smooth Y/N Nodule Y/N; Size _____ Symmetric Y/N; Tender Y/N

CURRENT MEDICATIONS -

Patient Name_____ **DOB**_____

Are you currently taking any medication? No_____ **Yes** _____ If yes please list all medications below and **include over the counter medication(s and any dietary, herbal or vitamin supplements)** This office may import current filled medications from your pharmacy.

_____

Medication Name	**Dosage**	**HOW DO YOU TAKE YOUR MEDICATION? Circle One**	**Frequency (how often)**	**OFFICE COMMENTS (Changes, Stop date etc.)**
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
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		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		
		By Mouth / Injection Topical / Other_____		

Are you **allergic** to any medications? **No**_____ **Yes** _____ **If yes, please list**:_____

Patient Signature:_____Date:_____ (Signature Required)

FOR OFFICE USE ONLY – Please do not write below this line

Above list reviewed with patient with any changes noted, dated and initialed to the right.

EAD UROLOGY
1216 N. University Drive, Plantation, FL 33322
Phone: (954) 472-4072 Fax: 954-472-4044

OFFICE POLICIES / FEES

Patient Name: _____ Date of Birth: _____

PLEASE CAREFULLY READ, INITIAL AND SIGN EACH SECTION

RADIOLOGY / LAB TESTING

I understand that Dr. Daniel Ead may order lab work or radiology studies on my behalf as part of my urological care. I understand that it is **MY RESPONSIBILITY** to have the requested tests performed as well as follow up in the office to receive my test results. Radiology and biopsy results **will not** be given over the phone. We do not call patients with normal lab results. **Please call the office 5 days after your study if you do not have a follow-up appointment so that we can obtain the results of your study / lab. _____INITIAL**

FEES FOR FILLING OUT PAPERWORK

Effective May 1, 2023, we will have to charge for filling out paperwork due to the time it takes the physician to complete it. Fees are as follows:

- FMLA Paperwork - $25.00 – First time, $15 each amendment **_____INITIAL**
- Disability Paperwork - $35 – First Time, $15 each amendment **_____INITIAL**
- Life Insurance Paperwork - $25 First time, $15 each amendment **___INITIAL**

Patient Signature_____ Date: _____

PATIENT PERMISSION TO COMMUNICATE INFORMATION WITH DESIGNATED INDIVIDUALS (WHO CAN WE TALK TO?)

Our physicians and staff know that communicating with you about your healthcare is important. By completing this form, you give us permission to provide messages, and/or discuss information about your healthcare with the individuals designated below. I understand that I may cancel or update this information at any time by notifying a representative of the physician office.

1. **I give permission** to allow physicians and staff to discuss relevant medical, billing, and insurance information with the individuals listed below (examples, spouse, relatives, friend, etc.). I understand that my healthcare provider will use professional judgment to determine what information about my healthcare may be discussed with the designated individuals below*.

Involved Individual	Relationship to Patient	Phone Number

Patient/Authorized Representative Signature_____Date:_____Time: _____**

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.

MEDICAL RECORDS RELEASE

General Medical Records Release and Authorization for Use or Disclosure for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____ Cell: _____

SSN: _____ _____ DOB: _____/_____/_____

I authorize the release the following information* (check all that apply)

□ All Records □ Billing Records □Laboratory / Pathology records

□ X-ray / radiology records □Pharmacy / prescription records □ Other: _____

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease, you are hereby authorizing disclosure of that information.**

These records are for services provided on the following date(s) : _____FOREVER OTHER_____.

Please send the records listed above to (use additional sheets if necessary)

Dr. Daniel Ead
1216 N. University Drive
Plantation, FL 33322

FAX: 954-472-4044

The information may be used/disclosed for each of the following purposes:

- At my request
- For my health care
- For payment/insurance
- For employment purposes
- Legal, Disability, Social Security

This authorization will be valid for one year from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization if **VOLUNTARY** and I may refuse to sign this authorization. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and there are no claims or orders pending or in effects that would prohibit limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Patient or patients Representative Name Printed Date

_____

Patient or Patients representatives' signature

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge: A copy of the Notice of Privacy Practices was offered to me. It was also prominently displayed in the waiting room to review.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name

****

FOR OFFICE USE ONLY

If an acknowledgement is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgement: _____

Reason acknowledgment was not obtained:

□ Patient/family member received notice but refused to sign acknowledgment

□Emergency treatment situation

□Patient was incapacitated and no family member was present

□Unable to communicate due to language barriers

□Other (Please describe below)

_____

_____

_____ _____

Signature of Employee Date