



Arizona State Urological Institute
The Center for Comprehensive Urological Care

Patient Name: _____ Date of Birth: ____/____/____

Please answer the following to the best of your ability. If you are unable to fill out these forms or need assistance, ask the front desk for additional help.

I authorize the following people to access my medical records and information:

Name (First and Last)	Date of Birth (MM/DD/YYYY)	Relationship
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

Arizona State Urological Institute (ASUI) and Arizona Oncology (AO) share the same commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. Please select a security question below to verify with the individuals whom are authorized to access and discuss your medical records with our office.

Security PIN: _____

Security Question: _____
 Answer: _____

Security Phrase: _____

Ok to leave a detail message: No Yes

List Number ok to leave message on:

Do you have any children? [] Yes [] No If yes, how many: _____

Do you currently smoke? [] Yes [] No If yes, how often: _____

Are you a former smoker? [] Yes [] No If yes, how many years: _____

Do you chew tobacco? [] Yes [] No

Do you drink alcohol? [] No [] socially [] 1-2 per day [] 3-4 per day [] Over 4 per day

Have you ever used illegal drugs? [] Yes [] No

If yes, list what kind(s): _____

Are you currently sexually active? [] Yes [] No

Have you ever had a sexually transmitted disease (STD)? [] Yes [] No

If yes, please list type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____



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PATIENT CONTACT LIST

Please provide current information that our office can use to contact individuals on your behalf in case of disconnected number, difficulty with reaching you, or an emergency.

Emergency Contact: Indicate any person who should be notified in case you experience a medical emergency while at our office.

EMERGENCY CONTACT

Name: _____ Date of Birth: ____/____/____

Relationship: _____

Primary Phone: (____)____-____ Alt. Phone: (____)____-____

Non-Emergent Contact: Indicate persons who we may contact if we are having difficulty reaching you. Note: Unless you authorize the following individuals to access your protected health information (PHI), they may not receive test results or office visit information on your behalf.

NON-EMERGENT CONTACT #1

Name: _____ Date of Birth: ____/____/____

Relationship: _____

Primary Phone: (____)____-____ Alt. Phone: (____)____-____

NON-EMERGENT CONTACT #2

Name: _____ Date of Birth: ____/____/____

Relationship: _____

Primary Phone: (____)____-____ Alt. Phone: (____)____-____

NON-EMERGENT CONTACT #3

Name: _____ Date of Birth: ____/____/____

Relationship: _____

Primary Phone: (____)____-____ Alt. Phone: (____)____-____

Print Patient Name: _____ Date: ____/____/____

Signature of patient or patient representative



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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patients Name: _____ Date of Birth: _____/_____/_____
Other Name: _____ Phone Number: (____) - _____
Address: _____ Social Security Number: _____

I hereby authorize, (Physician, Hospital or group):

To release information to:

Arizona State Urological Institute (ASUI)
2730 S. Val Vista Drive, Building 13, Suite 177
Gilbert, AZ 85295
Phone: (480) 394 - 0200 | Fax: (480) 394 – 0202

For the following purposes: _____

OR

All Records

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

I DO authorize the release of this type of information.

I DO NOT authorize the release of this type of information.

I understand that:

- I may revoke this authorization, except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization, unless the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization for my personal records.

Patients Signature:

Date

(Patients: This form allows our office to request medical records on your behalf from other physicians, hospitals, and care providers to better coordinate your care. Please fill this form out to the best of your ability.)



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Arizona State Urological Institute (ASUI) and Arizona Oncology (AO) share the same commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our Practice, and outlines your rights with regard to your health information. Please sign this form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Arizona Oncology Associates, P.C.:

Signature of Patient or Personal Representative

____/____/____
Date

Printed name of Patient or Personal Representative



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Please review the following checklist, and only check the medical conditions that apply to you. (If a condition applies to someone in your family, but you do not have it, do not check the box for that condition.)

Constitutional

- Recent appetite change
- Recent weight gain
- Recent weight loss
- Fatigue
- Fever
- Chills

Skin

- Hives
- Itching
- Rash

Allergy/Immunologic

- Cancer (Type: _____)
- Seasonal Allergies

ENMT

- Hearing change
- Nosebleeds
- Tinnitus (Ringing in ears)

Eyes/Head

- Dizziness
- Headaches
- Changes to vision

Respiratory

- Shortness of breath
- Cough
- Wheezing

Cardiovascular

- Edema (Swelling)
- Chest pain/discomfort
- Syncope (Fainting)

Gastrointestinal

- Bloody stools
- Recent bowel changes
- Abdominal pain
- Nausea
- Heartburn
- Diarrhea
- Constipation

Genitourinary

- Weak urinary stream
- Painful urination
- FEMALES: Vaginal discharge
- MALES: Penile discharge

Endocrine

- Diabetes (Type 1 or 2: _____)

Musculoskeletal

- Bursitis
- Gout
- Osteoporosis
- Muscle/joint stiffness
- Back pain/injuries
- Arthritis

Neurological

- Epilepsy
- Palsy
- Speech changes
- Stroke
- Tingling

Hematologic/Lymphatic

- Anemia (Low iron)
- Easy bruising