Atlantic Coast Urologic Implant Center
Dr. Barry Seidman
33 Overlook Road, Suite #408
Summit, NJ 07901

NEW PATIENT INFORMATION

Name: _____ **Date of Birth:** _____ **Age:** _____

Cell phone: _____ **Home phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Marital status:** _____

Employer: _____ **Work Phone:** _____

Emergency Contact: _____ **Relationship:** _____

Address: _____ **Phone:** _____

Primary Insurance Co. _____

Policy Number: _____ **Group Number:** _____

Secondary Insurance Co. _____

Policy Number: _____ **Group Number :** _____

Reason for today's visit: _____

Referred by: _____ **Primary Doctor:** _____

Present Weight: _____ **Present Height:** _____

Medical Problems: _____

Drug allergies: _____

Medications you are currently taking: _____

Pharmacy: _____ **Pharmacy Phone #:** _____

I HEREBY AUTHORIZE BARRY R. SEIDMAN, M.D. TO FURNISH INFORMATION TO THE INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS. FURTHERMORE, I ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED.

Signature: _____ **Date:** _____

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REVIEW OF SYSTEMS

Please complete all questions and categories

Name _____ Date _____ Date of Birth _____

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Weight Loss	Y	N
Headache	Y	N
Allergic/Immunologic		
Hay Fever	Y	N
Drug Allergies	Y	N
Other _____		
Neurologic		
Dizziness	Y	N
Tremors	Y	N
Stroke	Y	N
Numbness	Y	N
Cardiovascular		
Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Heart Attack	Y	N
Heart Valve	Y	N
Endocrine		
Diabetes	Y	N
Tired/Sluggish	Y	N
Thyroid Disease	Y	N
Other _____		
Eyes		
Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Gastrointestinal		
Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heart Burn	Y	N
Black Stools	Y	N

Integumentary		
Skin Rash	Y	N
Itching	Y	N
Unexplained Perspiration	Y	N
Musculoskeletal		
Arthritis	Y	N
Joint Pain	Y	N
Neck/Back Pain	Y	N
Ear/Nose/Throat		
Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Respiratory		
Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Emphysema/Bronchitis	Y	N
Hematological		
Swollen Glands	Y	N
Bleeding Problem	Y	N
Hepatitis	Y	N
HIV	Y	N
Other _____		
Psychological		
Suicidal	Y	N
Depression	Y	N
Genitourinary		
Blood in Urine	Y	N
Kidney Stones	Y	N
Urinary Tract Infection	Y	N
Painful Urination	Y	N
Urinary Leakage	Y	N
Sexual Dysfunction	Y	N
Other _____		

PHYSICAN COMMENTS/NOTES:

Physician _____ Date _____

BARRY R. SEIDMAN, M.D.
Diplomate, American Board of Urology

INFLATABLE PENILE PROSTHESIS * PROSTATE DISEASE * CYBERKNIFE
GENITOURINARY CANCER * SEXUAL DYSFUNCTION * INCONTINENCE

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

I. ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE I HAVE RECEIVED A COPY OF DR. BARRY R. SEIDMAN'S NOTICE OF PRIVACY PRACTICE

PATIENT'S NAME _____

DATE OF BIRTH _____

SIGNATURE OF PATIENT/PATENT/GUARDIAN _____

DATE _____

II. DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS, CAREGIVERS.

I AGREE THAT DR. BARRY R. SEIDMAN MAY DISCLOSE CERTAIN PORTIONS OF MY HEALTH INFORMATION TO A FAMILY MEMBER, CLOSE PERSONAL FRIEND OR OTHER CAREGIVER BECAUSE SUCH PERSON IS INVOLVED WITH MY HEALTHCARE OR PAYMENT RELATING TO MY HEALTHCARE.

I DESIGNATE THE FOLLOWING PERSONS LISTED BELOW AS PERSONS INVOLVED WITH MY HEALTHCARE OR PAYMENT RELATING TO MY HEALTHCARE. I UNDERSTAND THAT I AM NOT REQUIRED TO LIST ANYONE. I ALSO UNDERSTAND THAT I MAY CHANGE THIS LIST AT ANY TIME.

PRINT NAME: _____

PRINT NAME: _____

PRINT NAME: _____

PRINT NAME: _____

PRINT NAME: _____

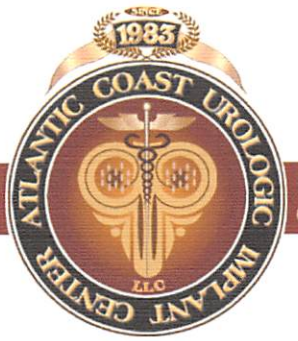
PRINT NAME: _____

SIGNATURE OF PATIENT/ PARENT/ GUARDIAN _____

DATE _____

33 Overlook Road, Suite 408 Summit, NJ 07901 908-219-4479 Fax 908-219-4647 * 10 Mountain Blvd. Warren, NJ 07059 908-561-6691

BARRY R. SEIDMAN, M.D.
Diplomate, American Board of Urology



INFLATABLE PENILE PROSTHESIS ★ PROSTATE DISEASE ★ CYBERKNIFE
GENITOURINARY CANCER ★ SEXUAL DYSFUNCTION ★ INCONTINENCE

Name: _____ **Date:** _____

Chief Complaint ***(Please describe in detail the Main Reason for your visit today.)***

_____
_____
_____
_____

History of Present Illness ***(Briefly describe the location of the problem, its severity and how long it has been going on. How long does it last? Is it constant or variable? Any aggravating and relieving factors? Any related problems, e.g. nausea, rash, headache..?)***

_____
_____
_____

Past/Current Medical Problems **None:** _____

(Please list any serious illnesses (Example: diabetes, tuberculosis, cancer, heart disease, etc.)

_____
_____
_____

Hospitalizations/Surgeries: **None:** _____

Date	Hospital	Surgery	Comments

History of Radiology Studies:

Date	Radiology/Test	Results

33 Overlook Road, Suite 408 Summit, NJ 07901 908-219-4479 Fax 908-219-4647 ★ 10 Mountain Blvd. Warren, NJ 07059 908-561-6691

Name: _____ **Date:** _____

Current Medications

Drug Name	**Dose**

Herbal/Non Prescription Medications (please list)

_____

_____

Allergies **None** _____

Allergies	**Severity**	**Status**	**Reaction**

PSA **None** _____

Date	**Results**	**Date**	**Results**

Family Medical History **None** _____

Relation	**Age**	**Health**	**Comments**

Social History

How long have you been smoking? _____				
Tobacco (chew)	**Yes** ___ **No** ___			
Alcohol	**Yes** ____**No** ___			
Drugs	**Yes** ___ **No** ___			
Coffee	**Yes** ___ **No**___			
Tea	**Yes** ___ **No** ___			
Caffeine	**Yes** ___ **No**___			
Exercise	**Yes** ___ **No**___			
Blood Transfusion	**Yes** ___ **No** ___			
Foreign Travel	**Yes** ___ **No** ___			
Marital Status	___ **Married**	___ **Divorced**	___**Single**	___ **Other**
HIV Test	___ **Negative**	___ **No Result**	___ **Not done**	___ **Positive**
Hepatitis B	___ **Negative**	___ **Normal**	___ **Positive**	
Race _____				
Number of Children _____				
Born ___ **In country Out of Country** _____				
Occupation _____				

Dear New Patient,

Thank you for choosing Dr. Barry Seidman.
The doctor and staff look forward to introducing you to the benefits of quality urological care.

Please fill out the attached forms and bring them with you along with your Driver's license, insurance card(s), a list of your medications, **with their respective Dosages**, and a list of any drug or food allergies you have.

In addition, if referral is required by your insurance bring with you at time of visit.

The address is 33 Overlook Road MAC 1 building Suite 408 Summit, NJ 07901

With Warms Regards,
Dr. Barry Seidman and Staff

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **DR. SEIDMAN** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.