Perito Urology

Paul E. Perito, M.D., P.A.

135 San Lorenzo Ave. Suite 540
Coral Gables, Florida 33146
Tel: (305) 444-2920
Fax: (305) 446-9377
www.peritourology.com

PATIENT INFORMATION:

Patients Name: ____ Date: ________________________
Nombre del paciente Fecha

Address: ____ City: _________________________
Direccion Ciudad

State: _______________ Zipcode: ___________ Telephone: ______________________________________
Estado Codigo Telefono

Email: ____

Date of Birth: _________ Sex: _______________ Social Security #: _________________________________
Fecha de nacimiento Sexo Numero de seguro social

Marital Status: ________ Patients Occupation: ____
Estado civil Ocupacion del paciente

Place of Employment: ____
Lugar de Empleo

Address: ____
Direccion

Person responsible for payment: ____
Persona responsible del pago

Referred by: ___________________________ Telephone of Referring Physician: ________________________________
Referido por Telefono del medico que lo refiere

Insurance Company: ____
Compania de seguro

Insurance Company Address: ____
Direccion de la compania de seguro

Insurance Company Telephone: ____
Telefono de aseguradora

Name of Insured: ____
Nombre del asegurado

Policy #: ________________________________ Group #: ___________________________________
Numero de polica Numero del grupo

How did you hear about Perito Urology? ____
Como se entero de

TV: _____ Magazine: _____ Radio: _____ Internet: _____ (if so, where?) ____

Patient or Physician Referral: _____ (if so, who may we thank?) ____

PATIENT RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Dr. Paul E. Perito of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries any information needed for this or a related Medicare claim. I request payment of medical insurance benefits to the party who accepts assignment. I understand I am financially responsible for charges not covered by this authorization.

Patients Signature: ____ Date: ______________________________
Firma del paciente Fecha

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PATIENT INFORMATION

Patient Name: ____
Nombre

Date of Birth: ____
Fecha de nacimiento

LIST OF MEDICATIONS / LISTA DE MEDICINAS:

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

8) ____

9) ____

10) ____

PHARMACY NAME: ____
Nombre de la farmacia

PHARMACY PHONE NUMBER: ____
Numeros de telefono farmacia

PHARMACY ADDRESS:
Direccion de la farmacia

____

____

____

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ADDITIONAL HEALTH INFORMATION

Patient Name: ____

Reason for your visit?
Razon por su visita?
____

____

Are you a patient with diabetes? YES_____ NO_____
Usted es un paciente diabetic? SI_____ NO_____

Are you on any anticoagulant treatments?
(Aspirin, Coumadin, Plavix, Ecotrim, Advil, Celebrex, etc.) YES_____ NO_____
Esta usted en algun tratamiento con anticoagulants?
(Aspirina, Coumadin, Plavix, Ecotrim, Advil, Celebrex, etc.) SI_____ NO_____

Are you allergic? YES_____ NO_____
If yes, what are you allergic to?____
Tienes alguna allergia? SI_____ NO_____
Si tienes allergias, quales son?____

Do you have any cardiovascular issues?
(Stents, Pace maker, Defibrillator, etc) YES_____ NO_____
Usted tiene algu dispositivo cardiovascular?
(Stents, Pace maker, Defibrillator, etc) SI_____ NO_____

Do you have any follow-up appointments with your cardiologist? YES_____ NO_____
If so, When? ____
Usted tiene alguna cita par aver a su cardiologo? YES_____ NO_____
Cuando? ____

What is the name and number of your cardiologist?
____

Cual es el nombre y numero de su cardiologo?
____

Do you smoke? YES_____ NO_____
Usted fuma? SI_____ NO_____

PATIENT SIGNATURE: ____________________________________ DATE: ______________

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ADDITIONAL HEALTH INFORMATION

TODAY'S DATE_____/_____/_____ DATE OF LAST PHYSICAL EXAM_____/_____/_____

LAST NAME____________________ FIRST NAME_______________ MIDDLE____________

Social Security No. _______________ DATE OF BIRTH_____/_____/_____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

History of Present Illness

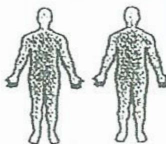
Please answer the following questions

Location of the problem

Abdomen Back Leg

Other____________________

Front Back



On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other____________________

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other____________________

How long does the problem last?

30 minutes 1 hour It is always there

Other____________________

Is anything else occurring at the same time?

YES No If yes, please explain.

Nausea Rash Headaches

Other____________________

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other____________________

Does the problem interfere with your normal functions?

YES No If yes, please explain____________

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery Date

Do you smoke? Y N

If yes, how much? ____________________

Do you drink? Y N

If yes, how much? ____________________

Are you on any medications? Y N (If yes, list all.)

Are you on a special diet? Y N (If yes, please explain)

Do you have allergies? Y N (If yes, Please explain.)

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REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Headache Y N
- Other____________________

Eyes
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other____________________

Allergic/Immunologic
- Hay Fever Y N
- Drug allergies Y N
- Other____________________

Neurological
- Tremors Y N
- Dizzy spells Y N
- Numbness/tingling Y N
- Other____________________

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other____________________

Gastrointestinal
- Abdominal pain Y N
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Other____________________

Cardiovascular
- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other____________________

Integumentary
- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other____________________

Musculoskeletal
- Joint pain Y N
- Neck pain Y N
- Back pain Y N
- Other____________________

Ear/Nose/Throat/Mouth
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Other____________________

Genitourinary
- Urine retention Y N
- Painful urination Y N
- Urinary frequency Y N
- Other____________________

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other____________________

Hematologic/Lymphatic
- Swollen glands Y N
- Blood clotting problem Y N
- Other____________________

Psychologic
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide? Y N
- Other____________________

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the following person ____to have access to my medical information.

I authorize Dr. Perito and staff to discuss my lab results, pathology results, appointment scheduling and any other matter associated with my health, and discuss results over the phone with me.

PATIENT SIGNATURE: ____

PHONE #___________________________

Yo autorizo a ____ tener acceso a mi informacion medica. Incluyendo resultados o procedimientos.

Yo autorizo al Dr. Perito y su oficina discutir mi informacion medica como resultados, procedimientos, citas por medio de llamada telefonica al paciente.

FIRMA DEL PACIENTE: ____

NUMERO DE TELEFONO___________________________

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CONSENT FOR TREATMENT

I hereby authorize Paul E. Perito, M.D. and whomever be may designate as his assistants to perform urological, urodynamics and/or imaging examinations, provide urological services and perform other recommended diagnostic procedures and interventions directed by appropriately licensed professionals. If any unforeseen condition arises in the course of the process calling for procedures in addition to or different from those not complicated, I further request and authorize, Paul Perito, M.D. to do whatever is deemed necessary and advisable. The nature and the purpose for these procedures, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made to me as to the results that may be obtained.

POWER OF ATTORNEY

I expressly authorize and give power of attorney to Paul Perito, M. D., P.A. and his billing agent for the signing and completing of any form in the completion of my claims and endorsing any check made payable to me in support of processing or making payment of claims for any charges incurred by me at the office of Dr. Paul Perito. Further, Dr. Perito acknowledges that he is entitled to receive payment for only those charges which are incurred for his treatment and any overpayment will be refunded appropriately and timely.

ASSIGMENT OF BENEFITS AUTHORIZATION

I authorize Paul Perito, M.D., P.A. and his billing agent to release medical records and any information to any insurance company, employer, adjuster, or attorney that will assist in the payment of a claim. I further authorize all hospitals, physicians, medical clinics, attorneys, employers, and insurance company to release any financial or medical information as of and prior and in the future related to this claim. I hereby assign any and all benefits that I am eligible to receive for care rendered to me by Dr. Paul Perito and staff in consideration of this assignment this office extends partial credit. I also request that payment of authorized Medigap benefits be made on my behalf to Paul Perito, M.D., P.A.

MEDICARE LIFETIME AUTHORIZATION AND ASSIGMENT

Lifetime Medicare B signature authorization for services starting date: ____________. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers, or to the billing agent of Paul Perito, M.D., P.A. any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

CONFIDENTIALITY AND PATIENT BILL OF RIGHTS

Individuals with access to your file are those members of the staff of Paul E. Perito, M.D., P.A. directly related to the provisions of your services. There are circumstances when confidentiality will be limited (e.g., court-ordered appearances, intention to injure self or other, child abuse, criminal or civil litigation); otherwise, confidentiality under all other instances will be maintained. I understand the limits of confidentiality and consent as well as accept this agreement.

PATIENT SIGNATURE: ____ DATE: _________________________

WITNESS____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMAITON

SECTION A: Patient Giving Consent

NAME: ____

ADDRESS: ____

TELEPHONE: ___________________________ SOCIAL SECURITY: __________________________

SECTION B: To the Patient – Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected heath information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Contact Person: Dr. Paul Perito's Office

DO NOT RELEASE INFORMATION TO: ____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE: ____ DATE: ______________________

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PENILE IMPLANT DISCUSSION

Patient Name: ________________________________

Penile Implant Discussion today.

Pt is suffering from organic impotence and is now opting for penile implant surgery.

Today I have reviewed options such as PDE51's, PGE therapies, VCD's and penile implant. Pt is fully aware that of these, the implant is the most invasive, and is completely non-reversible. I have covered the risks in detail including, but not limited to infection and breakage, these two requiring further surgery or surgeries. Should infection occur the patient understands he might not ever even get back to his baseline pre-implant status.

The risks of infection, and malfunction not withstanding, other issues such as loss of penile length, girth and sensitivity were also covered. General lack of satisfaction with results, either patient or partner were covered. Changes in penile sensation and ejaculatory changes were covered. The fact that the distal end of the implant cannot always be placed all the way into the glans, this resulting in some degree of floppiness or lack of rigidity of the tip explained.

The patient understands that should some of the above problems occur they might not be covered by medical insurance and can be very expensive to treat.

Patient understands the importance of home care after the surgery, the importance of taking his antibiotics and of contacting us should any problems occur prior to his scheduled follow-up appointment.

Patient understands that he may not return to full activities until released by me.

With all of this taken into account, he is opting to proceed with penile implant surgery.

Paul E. Perito
DFM/dm1

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CONSENT FOR SURGERY

I hereby authorize Paul E. Perito, M.D. and / or assistants as may be selected by said physician to treat the following condition(s)

IMPOTENCE (INABILITY TO ACHIEVE OR MAINTAIN A SATISFACTORY ERECTION)

PLACEMENT OF PENIL EPROSTHESES

Possible risks associated with this procedure(s)

PAIN OR DISCOMFORT IN AREA OF PROTHESIS REQUIRING REMOVAL. INFECTION AROUND PROSTHESIS REQUIRING REMOVAL. PATIENT OR PARTNER DISSATISFACTION WITH PROSHESIS PERFORMANCE. LOSS OF PENILE TISSUE. DECREASED SENSATION. URETHRAL INJURY, COLD GLANS, BOWEL, BLADDER AND VASCULAR INJURY. INABILITY TO EJACULATE. AUTO INFLATION. HERNIATION OF RESERVOIR. DIFFICULTY OPERATING PUMP. PENILE IMPLANT FAILURE AND EVEN IMMINENT DEATH. SOME LOSS OF PENILE LENGTH SECONDARY TO EXISTING IMPOTENCE (**THERE WILL BE NO INCREASE**). POSSIBLE LACK OF FIRMNESS OF TIP (GLANS). INFECTION REQUIRING FURTHER SURGICAL REPAIR. ALTERNATIVE THERAPY MAY INCLUDE: MALLEABLE PROSTHESIS, VACUUM DEVICES, SELF-INJECTION THERAPY, PILLS.

I certify that this two (2) page form has been explained to me and that I have read it, or have had it read to me and that I understand its contents.

PATIENT OR GUARDIAN SIGNATURE: ____

DATE: ______________________________ TIME: ______________________________

PRINT NAME: __________________________ WITNESS: ___________________________

State law guarantees that you have both the *right* and *obligation* to make decisions concerning your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

The information that follows is the text from a standardized Surgical Consent Form. It is used for the most minor of procedures and the most complicated and serious ones. It is not meant to frighten you but rather to inform you that **ALL** procedures carry some risks. Many operations for instance, have only the remotest chance of needing blood transfusions, but yet blood transfusions are mentioned. This form hopefully will allow you to better understand your upcoming operation. If you don't understand something **ASK**.

I recognize that during the course of this operation, post-operative care, medical treatment, anesthesia or other procedures, unforeseen conditions may necessitate additional or different procedures than those set forth.

I therefore authorize my above physician, and their assistants or designees to perform such surgical or other procedures as are in the exercise of their professional judgment necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time the medical or surgical procedure is recommenced.

I have been informed that here are significant risks such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. I realize that new risks may exist or may be found in the future that are mentioned on this consent form.

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CONSENT FOR SURGERY

I acknowledge that no warranty or guarantee had been made to me as to the results of my procedure or cure of my condition.

I consent to the use of transfusion of blood and blood products as may be deemed necessary by my physicians. I understand that diseases can be transmitted via these blood products, including AIDS and hepatitis.

I acknowledge that any tissues or parts removed surgically may be disposed of by the hospital or physician in accordance with accustomed practice.

I understand that any aspect of this consent form that I do not understand can be explained to me in further detail by asking my physician(s) or their associates.

I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment; and the recognized serious possible risks, complications, and the anticipated benefits involved in the proposed treatment and the alternative forms of treatment, including non-treatment.

Patient or Guardian Initials: ____________________

The medical procedure or surgery stated on this form (page1). Including the possible risks, complications, alternative treatments (including non-treatment and anticipated results, was explained by me to the patient or his/ her representative before the patient or his/her representatives consented.

PHYSICIAN SIGNATURE: ______________________________________ DATE: ________________________

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PENILE IMPLANT PACKAGE EXCLUSIONS

The Package Excludes:

Charges for additional nights at the hospital.

Charges for pathologist or radiologist or other physician consultations.

Treatment for underlying diseases or complications such as infection, deep vein thrombosis, pulmonary embolism, etc, or other surgical complications.

Rehabilitation visits after the immediate post-operative period (included in the package are the first five follow up visits which include teaching)

Expenses associated to complications arising from surgical procedure, any other medically related complications or patient non-compliance.

Lifetime warranty covering **manufacturing defects** on implant only. Warranty provided by manufacturer and not by Dr. Paul Perito.

El costo de cirugia excluye lo siguiente:

Gastos adicionales por ingresos en el hospital.

Costo del potologo y el radiologo

Tratamiento referente a otras enfermedades or complicaciones tal como infecciones, thrombosis, embolismos.

Visitas de rehabilitacion siguimiento (las primeras cinco visitas despues de la cirugia son incluidas en el presupuesto)

Gastos asociados a complicaciones asociadas con el procedimiento quirurgico, asociados a problemas medicos o proglemas de desobedencia o incumplimiento por el paciente.

Garantia cubriendo **defectos de manufactura** de por vida, solamente. La garantia es ofrecida for la compania manufactora y no por el Dr. Perito.

PATIENT SIGNATURE: ____________________________________ DATE: ________________________
Firma Fecha

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PATIENT EVALUATION

1) EVALUATION COMPLETED: ____________________

2) AWARE OF ALTERNATIVE TREATEMENTS: ____________________

3) TYPE OF IMPLANT: ____________________

4) ANY OTHER QUESTIONS: ____________________

5) DOES YOUR WIFE HAVE ANY QUESTIONS: ____________________

6) AWARE OF RISKS OF SURGERY: ____________________

7) DATE AND TIME OF SURGERY: ____________________

8) TIME AND ARRIVAL AT HOSPITAL: ____________________

9) DO YOU HAVE A RIDE HOME: ____________________

10) DO YOU HAVE YOUR PRESCRIPTIONS: ____________________

A word again about penis size. As a reminder-this surgery will not increase the size of the penis. YOUR OWN penis size will determine the size of the implant used. You can get a fairly good idea of penis length after surgery by sitting in a tub of warm water and gently pulling up on the penis when completely relaxed. This will approximate the penis length you will have after your implant.

I, ____HAVE READ AND UNDERSTAND

DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT BEFORE SURGERY EXCEPT A SIP OF WATER TO TAKE YOUR ANTIBIOTIC PILLS.

I UNDERSTAND AND AGREE TO THE ABOVE AND ALL QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

PATIENT SIGNATURE: ____ DATE: ______________________

WITNESS NAME: ____ DATE: ______________________