GULFSTREAM
UROLOGY
ASSOCIATES, P.A.

Adam J. Ball, MD, FACS, Diplomate of the American Board of Urology

Patient Name: _____ **DOB:** _____

Reason for today's visit: _____

PLEASE PROVIDE AN UPDATED LIST OF YOUR MEDICATIONS OR LIST BELOW.

CURRENT PHARMACY: _____

Any surgeries or procedures since your last visit? _____yes _____no

If yes, _____

Any changes in drinking or smoking habits? _____yes _____no

If yes, _____

SINCE YOUR LAST VISIT, HAVE YOU NOTICED...

Any changes in your ability to urinate? _____yes _____no

Any burning while urinating? _____yes _____no

Any blood in your urine? _____yes _____no

Any difficulty starting or stopping your stream? _____yes _____no

Any severe urgency to urinate? _____yes _____no

Any difficulty with sexual activity? _____yes _____no

Any difficulty with control of your urine/incontinence? _____yes _____no

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DO YOU HAVE an ADVANCE CARE PLAN or SURROGATE DECISION MAKER?

***YES *** ***NO ***

Surrogate's Name: _____

Surrogate's Phone: _____

PCP's Name: _____

PCP's Number: _____

PATIENT SIGNATURE: _____ **Date:** _____

Office: (772) 465-2020 • Fax: (772) 465-2111

579 NW Lake Whitney Place, Suite 105 • Port St. Lucie, Fl 34986

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Patient Name: _____ DOB: _____

AUTHORIZATION FOR TREATMENT

(1) I hereby authorize Dr. Adam J. Ball, or a physician designated by him, or whomever he may designate as assistant to render medical care to me. I consent to care and treatment that may encompass laboratory, diagnostic, or medical treatment that my physician or his assistant may deem necessary for my health and well-being.

Receipt of Notice of Gulfstream Urology Associates, P.A. Payment Policy

(2) I hereby acknowledge receipt of Gulfstream Urology Associates, P.A.'s Payment Policy. The "Notice" provides detailed information about how the practice processes your account. I understand that the practice has reserved the right to change its policies and procedures that are described in the "Notice". I also understand that a copy of any future revisions will be provided to me or made available. I understand that if I cannot keep my follow-up appointment or my procedure appointment, I need to call Gulfstream Urology Associates, P.A. twenty-four (24) hours in advance to cancel. I agree to pay $50 (follow-up appt) or $100 (procedure appointment) if I do not comply.

I have read and I understand the above paragraphs (1) & (2). I hereby agree to each and every provision.

PATIENT SIGNATURE: _____ Date: _____

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