Confidential Medical History

Patient Name_____ **Date**_____

Current Symptoms:

All Negative ☐

Constitutional: fever chills weight loss
Eyes: blurred vision eye pain double vision
Neurological: tremors numbness/tingling dizziness
Endocrine: tired/sluggish diabetes excessive thirst
Gastrointestinal: bloody stool jaundice trouble swallowing
Cardiovascular: heart attack palpitations chest pain
Skin: skin rash boils persistent itch
Musculoskeletal: joint pain bone pain leg swelling
Ear/Nose/Throat/Mouth: ear aches sinusitis sore throat
Respiratory: wheezing coughing shortness of breath
Hematologic/Lymphatic: swollen glands clotting disorder
Psychologic: not satisfied with life depressed

Allergies:

No Allergies ☐

Substance/Medication	Reaction

Past Medical History:

None: ☐

Atrial Fibrillation	High Cholesterol	Anxiety	Enlarged Prostate
Coronary Artery Disease	Colitis (which kind)	Depression	Bladder Cancer
High Blood Pressure	Gastric Reflux	Asthma	Blood in the Urine
Heart Stents	Hearing loss	COPD or Empysema	Kidney Cancer
Stroke	Sinusitis	Colon Cancer	Kidney Stones
Diabetes (insulin dependent: Y N)	Arthritis	Lung Cancer	Prostate Cancer
Hypothyroidism	Spinal disc problems		Renal Failure
Hay fever/Allergies	Rheumatoid Arthritis		Urine Infections
Other/ Not listed:			

Surgeries:

None: ☐

	Date
	Date
	Date
	Date
	Date
	Date

Female Patients:

pregnancies	deliveries	c sections?	regular periods?

Family History: (in whom)

prostate cancer	kidney stones	kidney cancer	other significant:

Social:

Married: Y N	divorced	children ?	occupation:
Alcohol: Y N	amount weekly:		caffeine daily:
Tobacco: Y N	ever? Y N	amount and years:	years since?

Medications: (name,dose,how often) **None** ☐ **See List:** ☐

PATIENT INFORMATION SHEET (PLEASE PRINT)

Today's Date_____ Date of Birth _____Age_____

Patient's Name_____Single/Married/Other_____

Address_____

City_____State_____Zip Code_____

SS#_____

Home Phone(____) _____Cell(____)_____Other(____)_____

Email _____

(please note: without cell number, doctor may not reach you in an emergency or to answer questions)

Male Female Race_____Ethnicity_____

Preferred Pharmacy Name &Location_____

PRIMARY PHYSICIAN_____

REFERRING PHYSICIAN/OB/GYN_____

Employer Name_____WorkPhone(_____)_____

INSURANCE INFORMATION (IF OTHER THAN YOURSELF)

Spouse/Guardian_____

Employer Name_____ Work Phone(_____)_____

Date of Birth_____ SS#_____

How did you hear about Dr. Nurzia or Santarosa? (circle one) Direct Doctor Referral

Family Member Other Patient Insurance Company Internet Search

PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST SO THAT WE MAY COPY FOR YOUR FILE AUTHORIZATIONS

I AUTHORIZE DR. MICHAEL NURZIA OR DR. RICHARD SANTAROSA TO RENDER MEDICAL TREATMENT TO ME OR TO THE PERSON ON WHOSE BEHALF I HAVE LEGALLY SIGNED. I UNDERSTAND THIS FORM AND PERMIT A COPY OF AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

INSURED/AUTHORIZED SIGNATURE_____

DATE_____

Michael J. Nurzia M.D. | Richard P. Santarosa M.D.
166 West Broad Street, Stamford, CT 06902
(203) 356-9391

COMPREHENSIVE PATIENT AGREEMENT

Financial Agreement

I authorize Richard Santarosa M.D. and Michael J. Nurzia M.D. to render medical treatment to me or to the person on whose behalf I have legally signed. I understand payment is expected at the time of service for any and all treatment. The physician reserves the right to add a service charge of 1.65% per month on all accounts past 90 days or more. I agree to pay all billing and collection costs. I understand I am full responsible for any and all services rendered to me as guardian, or patient, of Dr. Nurzia, Dr. Santarosa, and/or his affiliated staff members. I authorize payment of medical benefits to Michael J. Nurzia M.D. or Richard Santarosa M.D. for any services furnished me by Dr. Nurzia or Dr. Santarosa. I understand that I am liable for any services that are termed as "noncovered" by my insurance company. I understand I am financially responsible for all services rendered to me if I, the patient or legal guardian, failed to follow the guidelines indicated by my insurance contract, i. e. neglect of obtaining the proper referral and/or precertification needed for any and all medical testing, radiographic evaluation, or laboratory testing, etc.

Additional Possible Fees Not Covered by Insurance:

No Show/ Missed appointments: There will be an **$45.00** administrative fee for appointments missed without at least 24 hour notice. For scheduled office diagnostic and surgical procedures, the no show fee is **$100.00.**

Returned Checks: It is official office policy to charge a fee of **$50.00** for administrative costs in the event of a returned (bounced) check, in addition to the amount of the check itself .

Cancelled Surgery: The physician reserves the right to charge a **$50.00 to $500.00** fee applied to cancelled or missed surgery without 48 hour notice.

Record Preparation: For record request to third parties (e.g. life insurance applications) an administrative fee of **$75.00** may be charged.

Laboratory Services Disclosure:

Urology is a medical and surgical subspecialty which makes extensive use of pathology services to analyze urine, tissue and other bodily specimens. Drs. Nurzia and Santarosa provide laboratory services for pathology specimens obtained in the office and submitted for analysis. The technical component(slide preparation) of these services are provided by The Stamford Hospital, and the professional (physician analysis) component is provided by a board certified pathologist employed by Drs. Nurzia and Santarosa.

Separate charges for these services may appear on your insurance statements, and seperate balance statements may be issued for these services. If you wish to have a different laboratory perform these services, please notify the physician.

Patient Communication

I hereby give Dr. Santarosa and/or Dr. Nurzia my permission to contact me to confirm appointments, to communicate information related to my personal health and treatment, and for purposes of obtaining payment through the information I give in my patient record. You may leave a message on my machine (voice mail) at home, work or cell phone if I am not available. I give permission for the doctors to speak with my family members, whom I identify, regarding my personal health and treatment.

Notice of Privacy Practices:

It is the policy of this office to treat protected health information in a manner outlined in the Health Information Privacy and Portability Act (HIPPA). I acknowledge that I have been given access to review this office's Privacy Policies Statement.

I HEREBY ACKNOWLEDGE I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE IN THIS COMPREHENSIVE PATIENT AGREEMENT:

Signature: _____Date:_____