BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

DEPARTMENT OF UROLOGY
Shapiro Center Suite 3B
725 Albany Street
Boston, MA 02118

T 617.638.8485
F 617.638.8487

Date _____

Your Name _____ **Age** _____ **Years Married** _____
Last **First**

Partner's Name _____ **Age** _____ **Years trying to conceive** _____
Last **First**

Pregnancies this marriage _____

Pregnancies prior to this marriage for you: _____ **Difficulty** _____
for your partner: _____ **Difficulty** _____

Have you ever had any of the following (Yes or No):

Undescended Testicle _____ **Work Exposure** _____

Surgery for Above _____ **Radiation Exposure** _____

Injury to testicle _____ **Vasectomy (year)** _____

Hernia Repair _____ **Prostate Surgery** _____

Varicocele Repair _____ **Exercise type** _____

Your job _____ **Partner's job** _____

Any other medical problems or types of surgery in the past (please list all): _____

_____

_____

Medication now / in the past year (dosages): _____
Supplements / herbal products: _____
Testosterone in any form: _____
Allergies to Medications: _____

Amount of Alcohol Use _____ **Any problems obtaining an erection** _____
Tobacco Use _____ **Any problems with ejaculation** _____
Drug Use _____

Partner Gynecologist/ Reproductive Endocrinologist: _____
Name

_____
Street **City** **State** **Zip** **Telephone #**

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Instructions for Semen Analysis

1) **Abstain from ejaculation for at least 2 or 3 days before your specimen collection appointment.**

2) **Arrive at the Shapiro Center, Department of Urology, Suite 3B a few minutes prior to your scheduled appointment time.**

3) **Have a seat in the waiting room and the lab technologist will check you in and will give you any further instructions.**

Remember that a late arrival may result in a delay of your follow-up appointment or possible appointment cancellation.

You semen analysis collection appointment has been scheduled for:

_____/_____/_____ AT ____: _____

Your follow up appointment with Dr. Robert Oates is scheduled for:

_____/_____/_____ AT ____: _____

Please make sure that you call our office at (617) 638-8485 or call Erica at (617) 638-1007 if you need to cancel your appointment. Your cooperation is appreciated.

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PATIENT REGISTRATION UROLOGY

Please Complete the Information Below		***Make Corrections***
LAST NAME		
FIRST NAME		
STREET		
CITY		
STATE		
ZIP		
HOME TELEPHONE		
WORK TELEPHONE		
CELLPHONE		
EMAIL ADDRESS		
MR#		
SEX		
MARITAL STATUS		
SOCIAL SECURITY #		
DATE OF BIRTH		
BIRTHPLACE		
ETHNIC BACKGROUND		
LANGUAGE		
INTERPRETER NEED-ED (YES / NO)		
VETERAN (YES / NO)		
PERSON TO NOTIFY IN CASE OF EMERGENCY		
NAME		
ADDRESS		
CITY STATE ZIP		
TELEPHONE	CELLPHONE	
RELATIONSHIP TO PATIENT		

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EMPLOYER
Office Address:
Office Telephone:
Occupation:

PRIMARY CARE PHYSICIAN	PROVIDER NO. Office use only
Name:	
Address:	
City, State, ZIP:	
Telephone and Fax:	

REFERRING PHYSICIAN **PROVIDER NO. Office use only**
Name:
Address:
City, State Zip:
Telephone and Fax:

PRIMARY INSURANCE CARRIER
Name of Insurance Carrier:
Address:
Subscriber Number:
Group Number:
Plan:

2nd INSURANCE CARRIER
Name of Insurance Carrier:
Address:
Subscriber Number:
Group Number:
Plan:

EXTENDED AUTHORIZATION AND CONSENT

I request that payment under the medical insurance program be made directly to the above named provider on any unpaid bills for services provided on or after the date ir below. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers of insurance compa information needed for this or a related Medicare or insurance claim. I understand that I am financially responsible for all charges not covered by my insurance, includir resulting from my failure to obtain the necessary referral and/or other authorizations from my primary care and/or referring physician when required. I permit a copy of t thorization to be used in place of the original.

Signature of patient or authorized representative_____Date_____