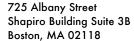
DEPARTMENT OF UROLOGY

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

T 617.638.8485 F 617.638.8487



			Date _	
Your Name		Age	Years Mar	ried
Last	First	_ 8		
Partner's Name		Age	Years tryin	ıg
Last	First	_ 6		ceive
Pregnancies this marriage _				
Pregnancies prior to this ma for	rriage for you: your partner:		Difficulty	
Have you ever had any of the	e following (<u>Yes</u>	or No):		
Undescended Testicle	e	Work	Exposure	
Surgery for Above		Radia	ntion Exposure	
Injury to testicle		Vased	ctomy (year)	
Hernia Repair		Prostate Surgery		
Varicocele Repair		Exercise type		
Your job		Partn	er's job	-
Any other medical problems Medication now / in the past Supplements / herbal produc Testosterone in any form: Allergies to Medications:	year (dosages):	-		
Amount of Alcohol Use Tobacco Use Drug Use	Any pi		ing an erection jaculation	
Partner Gynecologist/ Repro	ductive Endocri	nologist:	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	analys	is collec	tion app	ointment	t has b	een s	chedu	led for	:			
		/	/	AT	:		_					
Your follow	up ap	pointme	ent with	Dr. Robe	ert Oa	tes is	sched	uled fo	r:			
		/	/	AT	;							
Please makeneed to can		•			` /					at (617) 638-10	07 if you





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PATIENT REGISTRATION UROLOGY

Please	Complete the Info	rmation 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 I	N CASE OF EMERGEN	CY	
NAME			
ADDRESS	_		
CITY	STATE	ZIP	
TELEPHONE		CELLPHONE	
RELATIONSHIP TO PATI	ENT		

DEPARTMENT OF UROLOGY



725 Albany Street Shapiro Building Suite 3B Boston, MA 02118

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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: 2 nd INSURANCE CARRIER		
Name of Insurance Carrier:		
Address:		
Subscriber Number:		
Group Number:		
below. I authorize any holder of medical or other information needed for this or a related Medicare or insur	am be made directly to the above named provider on any unpaid bills for services provided on or after ation about me to release to the Social Security Administration, its intermediaries or carriers of insuran rance claim. I understand that I am financially responsible for all charges not covered by my insurance and/or other authorizations from my primary care and/or referring physician when required. I permit a	nce cor e, incl
Signature of patient or authorized representative	Date	