Florida Urology Center
BOARD CERTIFIED UROLOGISTS
www.floridaurology.com

Greg A. Parr, M.D.
Dane K. Hermansen, M.D.
Jay C. Guido, M.D.
Frank S. Melograna, M.D.
John K. Burgers, M.D.
Shawn W. Thomas, D.O.
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2025 Patient Information Update

Date:	Account #	Doctor: M P H G FM B	
Name:	SS#	DOB:	Age
Address:	City:	State:	Zip:
Primary Phone: ( ) - Cell ❒	Secondary Phone: ( ) - Cell ❒		

I authorize messages with medical information to be left at the above number(s) _____ (Patient Initials)

Others that F.U.C. may speak with about your health care: _____

Employer:	Phone:
Family Doctor:	Phone:
Your Pharmacy:	Phone:
What Lab do you use?	

Insurance: Primary _____

Insurance: Secondary _____

Assignment of Benefits: By signing below, I authorize the release of all medical information to my insurance company and request that payment of my insurance benefits be sent directly to the Florida Urology Center (unless full payment is made at the time of service).

Consent for Treatment: By signing below, I authorize treatment by the Florida Urology Center's physicians and their staff.

Medical Record Consent: By signing below, I authorize the Florida Urology Center's physicians and staff to obtain your medical records for treatment.

HIPAA: By signing below, I acknowledge that I have received a copy of the Notice of Health Information Practices. I understand that the medical practice/clinic may utilize an AI medical scribe during my consultation to assist our healthcare providers in documenting your medical care. All information handled by AI scribes is kept confidential and only used if compliant with applicable laws.

Contact: By signing below, I authorize all the phone numbers I have provided (including my mobile number) to be used to communicate with me regarding my treatment, billing or services referred.

Signature: _____ Date: _____

ALLERGY HISTORY	YES		YES	LIST ANY RECENT SURGERY
Aspirin		Tetracycline		
Codeine		Cipro		
Morphine		Latex		
Mycins		Iodine		
Penicillin		Sulfa		
Other:				

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Review of Symptoms | Check All That Apply

Updated 01/01/2025

CONSTITUTIONAL	Yes	RESPIRATORY	Yes	HEMATOLOGIC / LYMPH	Yes
Weight Loss		Cough		Easy Bruising	
Fatigue		Coughing Blood		Gums Bleed Easily	
Fever		Wheezing		Enlarged Glands	
EYES		Chills		Prolonged Bleeding	
Glasses / Contacts		**GASTROINTESTINAL**		**MUSCULOSKELETAL**	
Eye Pain		Heartburn		Joint Pain / Swelling	
Double Vision		Nausea / Vomiting		Stiffness	
Glaucoma		Constipation		Muscle Pain	
Cataracts		Change in B.M.'s		Back Pain	
EAR – NOSE - THROAT		Diarrhea		**SKIN**	
Difficulty Hearing		Difficulty Swallowing		Rash / Sores	
Ringing in Ears		Jaundice		Lesions	
Vertigo		Abdominal Pain		Itching / Burning	
Sinus Trouble		Black Stools		**NEUROLOGICAL**	
Nasal Stuffiness		**GENITOURINARY**		Seizures	
Frequent Sore Throat		Pain Urinating		Weakness / Paralysis	
Hoarseness		Burning		Numbness	
CARDIOVASCULAR		Frequency		Tremors	
Murmur		Nighttime		Memory Loss	
Chest Pain		Blood in Urine		**ALLERGIC / IMMUNOLOGIC**	
Palpitations		Difficulty Urinating		Hay Fever / Asthma	
Dizziness		History of Kidney Stones		Hives / Eczema	
Fainting Spells		History of Sexually Transmitted disease		PSYCHIATRIC	
Shortness of Breath				Anxiety / Depression	
Difficulty Lying Flat		Abnormal Discharge		Mood Swings	
Swelling Ankles / Other		**ENDOCRINE**		Difficult Sleep	
OTHER		Loss of Hair		**FEMALE ONLY**	
Cancer:		Heat / Cold Intolerance		Age of Onset of Periods	
Diabetes: ❒ Non-Insulin ❒ Insulin		Change in Nails		Age of Onset menopause	
				Are Periods Regular	Y | N

HABITS	YES	FAMILY HISTORY – PATIENT RELATIONSHIP	YES
Exercise Adequately		Cancer	
Coffee ( ) Cups per day		Diabetes	
Alcoholic Beverages ( ) per day		Heart Trouble	
Cigarettes / Cigars ( ) per day		High Blood Pressure	
Sex-Entirely Satisfactory		Stroke	
		Kidney Stones	

X-RAY HISTORY / DATE	YES	OTHER	
Chest		What is your current weight?	Lbs.
CT Scan			
Bone Scan		What is your height?	Ft. In.
IVP			
KUB			
MRI			

Port Orange Medical Center
790 Dunlawton Ave
Suite H
Port Orange, FL 32127
386-322-8880

Daytona Office
1620 Mason Ave
Suite E
Daytona Beach, FL 32117
386-673-5100

Ormond Office
300 Clyde Morris Blvd. Suite C
Ormond Beach, FL 32174
386-673-5100
Fax: 386-673-6014

Palm Coast Office
21 Hospital Drive
Suite 250
Palm Coast, FL 32164
386-445-8533

New Smyrna Beach
843 State Road 44
New Smyrna Beach,
FL 32168
386-957-3827

General Consent for Care and Treatment

MUST SIGN AND DATE BEFORE BEING SEEN

Patient Name: _____

Account#: _____

DOB: _____

1. I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to, physical examinations, administration of medications and vaccinations, recordings and/or photographs for diagnosis and/ or treatment, the taking of x-rays, blood draws, diagnostic tests, laboratory tests, Radiation Therapy and other minor procedures) to be performed by employees, including, but not limited to, physicians, advanced practice providers, nurses and assistants of Florida Urology Center and its subsidiaries (hereinafter "FLURO").

2. I understand that the nature of and the need for each procedure and treatment will be explained to me beforehand, and that I am free to refuse any one or all procedures or treatments if I so choose. I will have the opportunity to ask the doctor questions about the operation/procedure, and such questions will be answered to my satisfaction.

3. I consent to the present and future prescription and/or administration of medicines or drugs as may be deemed necessary by my/the patient's physician or others of the Florida Urology Center medical staff in the course of my/the patient's diagnosis and treatment with the understanding that the nature of and the need for such medicines or drugs will be explained to me beforehand, and that I shall always be free to refuse each and all of them if I so choose.

4. I understand that the explanation which will be given to me of the nature, intended purpose and the reasonable foreseeable risks, consequences, complications, benefits and alternatives of the examination(s), procedure(s) or treatment(s) which may be performed or used in the course of diagnosing or treating my/the patient's condition will not be exhaustive and that other risks and complications may arise, but the likelihood of their occurring is not reasonably foreseeable. I have been advised that if I desire a more detailed explanation prior to my consent, such an explanation will be given to me.

5. I understand that some important tasks may be performed by qualified medical practitioners other than the named surgeon(s)/physician(s), and I consent to their doing so. The specific tasks will be determined based on the practitioner's skill set, scope of practice under the applicable State law and will be performed under the supervision of FLURO surgeon(s)/physician(s). I have been explained what specific tasks these practitioners will perform, and I give my consent.

6. I understand that my protected health information will be used by FLURO, as necessary, for my treatment, to obtain payment for this treatment and for the healthcare operations of FLURO. I also understand that my protected health information will be disclosed to other FLURO affiliates if needed to further my treatment, to obtain payment for treatment and for healthcare operations of FLURO.

7. I understand that FLURO will warn the appropriate authorities and/or other individuals if my FLURO caregiver determines that I am harmful to myself or to others.

8. I consent to receive advanced biomarker or genomic testing based upon my healthcare needs as medically necessary and ordered by my healthcare provider, with my informed consent. Additionally, I authorize and consent for FLURO to use my non-identifiable bio-specimens and my data to develop and further support the advancement of science, which includes, but is not limited to, recommendations to participate in clinical trials, and the development of products, such as tests, drugs or medical devices that could be sold in the future. I understand that my non-identifiable bio-specimens and data may be used to learn about, prevent, or treat urologic issues.

9. I understand that performing a medication reconciliation to prevent adverse drug interactions and overdose is a critical aspect to my care. I give the Florida Urology Center permission to query and review my medication fill history including drug, dose, form, strength, prescriber provider and pharmacy by using Greenway Health EMR.

10. I understand that the medical practice/clinic may utilize an AI medical scribe/virtual scribe during my consultation to assist our healthcare providers in documenting your medical care. All information handled by an AI/virtual scribe is kept confidential and only used if compliant with applicable laws.

I confirm that I have read and fully understand this document, that I have been given the opportunity to ask questions about the operation/procedure and have had my questions answered satisfactorily, and that I am eligible to give this consent.

Patient and/or Guardian

Signature: _____

Date: _____

❒ Verbal consent obtained, unable to sign