

***Advanced Urology Medical Center***

*Alfred A. Sidhom, M.D.*

*Manilal Mehta, M.D.*

*Daniela Botic, P.A.*

Patient \_\_\_\_\_  
Last Name First Name Middle Initial

Responsible Party (if a minor) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex: M or F Birth Date \_\_\_\_\_ Marital Status: S M W D Other \_\_\_\_\_

Race: \_\_\_\_\_ (Optional) Primary Language \_\_\_\_\_

Social Security # \_\_\_\_\_

Primary Care/Referring Physician \_\_\_\_\_

Primary Care Phone # \_\_\_\_\_ Referring Phone # \_\_\_\_\_

Employment Status: Employed (FT) Employed (PT)  
Self Employed Retired Not Employed

Employer \_\_\_\_\_ Student Status: FT – PT – None

Responsible Party \_\_\_\_\_ Relation: \_\_\_\_\_

In case of an emergency, who should be notified? \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Primary Insurance \_\_\_\_\_ Member # \_\_\_\_\_

Name of Sec. Insurance (if any) \_\_\_\_\_ Member # \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

.....  
**Insurance Assignment and Release**

I certify that I have insurance coverage with \_\_\_\_\_  
Name of Insurance Company (ies)

I understand that if my insurance benefits and/or eligibility are not approved by my health plan (HMO or PPO) then I am financially responsible and agree to pay for all charges related to services provided to the patient(s).

The above-named facility may use my health care information and may disclose such information to the above-named Insurance Company (ies) and for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Signature \_\_\_\_\_

Parent or Guardians Signature (if minor) \_\_\_\_\_

NAME: \_\_\_\_\_  
ACCT: \_\_\_\_\_

Advanced Urology Medical Center  
1211 W. La Palma Ave. #502  
Anaheim, CA 92801

**FEMALE**  
**UROLOGY HISTORY**

	YES	NO
Do you have any troubles urinating? (specify) _____ _____ _____	_____	_____
Do you urinate more than 5 times/day?.....	_____	_____
Do you get up at night to urinate?.....	_____	_____
How many times? _____ times.		
Do you find it hard to start urinating?.....	_____	_____
Do you find yourself straining to urinate?.....	_____	_____
How is your urine stream? Strong _____ Medium _____ Weak _____		
Does it take a longer time to urinate?.....	_____	_____
Is urination painful?.....	_____	_____
Is the pain Before _____ During _____ or After _____ urinating?		
Do you have to hurry to reach the bathroom?.....	_____	_____
Do you leak urine if you don't reach the bathroom?.....	_____	_____
Do you feel pressure in the bladder area?.....	_____	_____
Is it relieved by urination?.....	_____	_____
Do you need to urinate again after few minutes?.....	_____	_____
Is your urine bloody or dark colored?.....	_____	_____
Has it ever been in the past?.....	_____	_____
Do you ever lose urine when you cough/sneeze/strain?.....	_____	_____
Do you ever lose urine during sleep?.....	_____	_____
Do you notice dribbling of urine after urinating?.....	_____	_____
Do you have any unusual vaginal Burning/Itching/Discharge? .....	_____	_____
Do you have any menstruation problems? .....	_____	_____
.....	_____	_____
How many times, if any, have you been pregnant? _____ times.....	_____	_____
How many children born alive? .....	_____	_____
Do you take birth control pills? .....	_____	_____
What was the date of your last menstruation? .....	_____	_____
Do you bruise easily?.....	_____	_____
Have you had any lumps on your neck, armpit or groin?.....	_____	_____
Do you have severe back pain?.....	_____	_____
Have you had back injury or surgery?.....	_____	_____

**PAST MEDICAL HISTORY**

PATIENT NAME: \_\_\_\_\_

Did you ever have any of the following illnesses? Mark Yes or No.

	Yes	No		Yes	No
Glaucoma/Cataract	_____	_____	Stomach/Duodenal ulcer	_____	_____
Other Eye problems	_____	_____	Diverticulosis/Colitis	_____	_____
Deafness	_____	_____	Gallbladder trouble	_____	_____
Bronchitis/Asthma	_____	_____	Kidney Problem/Stones	_____	_____
Emphysema	_____	_____	Bladder Problem/UTI	_____	_____
Pneumonia	_____	_____	Over Active Bladder	_____	_____
Anemia	_____	_____	Prostatitis/BPH	_____	_____
Tuberculosis	_____	_____	Convulsions/Seizures/Stroke	_____	_____
Neurologic disease	_____	_____	Arthritis disease	_____	_____
High blood pressure	_____	_____	Thyroid disease	_____	_____
Heart attack/Angina	_____	_____	Diabetes	_____	_____
Other Heart condition	_____	_____	Hepatitis/Liver	_____	_____
Heart murmur	_____	_____	Cancer or tumor	_____	_____
HIV	_____	_____	Mental illness//Depression	_____	_____
High Cholesterol	_____	_____	Bleeding tendency	_____	_____
			Sexual Transmitted Disease	_____	_____

Did you have any Weight change?.....Gain \_\_\_\_\_ Loss \_\_\_\_\_

How many cigarettes do you smoke in a day? \_\_\_\_\_/day NO \_\_\_\_\_

How many alcoholic beverages do you consume in a week \_\_\_\_\_

Do you use Marijuana or Hard Drugs?.....YES \_\_\_\_\_ NO \_\_\_\_\_

How much coffee or tea do you usually drink?.....Coffee/Tea \_\_\_\_\_ cups/day

Do you have any Sexual problems?.....YES \_\_\_\_\_ NO \_\_\_\_\_

List all previous Surgeries: \_\_\_\_\_  
 \_\_\_\_\_

List all Allergies: \_\_\_\_\_  
 \_\_\_\_\_

List all Medications, with doses, including aspirin and over the counter drugs \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Which of your blood relatives have had the following diseases:  
**Diabetes, High blood pressure, Heart Disease, Cancer, Stones, Tuberculosis**  
 \_\_\_\_\_  
 \_\_\_\_\_

If any parent or sibling is deceased state the cause of death:  
 \_\_\_\_\_  
 \_\_\_\_\_

List all previous hospitalizations and the reasons:  
 \_\_\_\_\_  
 \_\_\_\_\_

PHYSICIAN USE ONLY – All Other Systems Negative







Advanced Urology  
Medical Center

**Alfred A. Sidhom, M.D., P.C.**

*Diplomate American Board Urology  
Fellow American College of Surgeons  
Adult and Pediatric Urology*

1211 W. La Palma Ave.  
Suite 502  
Anaheim, CA 92801

(714) 776-7090  
Fax: (714) 776-5632

## AUTHORIZATION FOR RELEASE OF INFORMATION

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.**

**I understand that this authorization is voluntary. I understand that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.**

Patient name: \_\_\_\_\_ ID # \_\_\_\_\_

Persons/organizations receiving information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Specific description of information to release (including appointment dates and times):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I understand that I may revoke this authorization at any time by notifying the providing organization in writing.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

Printed name of patient's representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_

## Notice of Privacy Practices Acknowledgement

### ADVANCED UROLOGY MEDICAL CENTER

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to comply with my requested restrictions.

Patient Name \_\_\_\_\_

Patient Representative \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices" but was unable to do so, as documented below:

Date:	Initials:	Reason: