

PATIENT REGISTRATION

(Please Print & Complete in Full)

PATIENT INFORMATION			MEDICAL RECORD #		
First Name	Middle Initial	Last Name			
Address		City	State	Zip	
Social Security #	Date of Birth	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Phone	Ethnicity	Race: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Other		Preferred Language	
Work Phone	Referring Doctor		Referring Doctor Phone		
Cell Phone	Primary Care Physician (PCP)		PCP Phone		
Email		Pharmacy (Name/Street Address/Phone)			

EMERGENCY CONTACT		
Emergency Contact Name		Relationship
Home Phone	Work Phone	Cell Phone

RESPONSIBLE PARTY (IF OTHER THAN PATIENT, example: POA, parent of child)				
Responsible Party Name			Relationship	
Home Phone	Work Phone		Cell Phone	
Address		City	State	Zip
Date of Birth	Social Security #		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
If patient is a child, lives with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ Name of Person (With Whom Child Lives With): _____				

INSURANCE INFORMATION			
Primary Insurance Name	Policy/ID #	Secondary Insurance Name	Policy/ID#
IPA	Group #	IPA	Group #
Subscriber Name	Subscriber DOB	Subscriber Name	Subscriber DOB

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but not limited to co-pays, deductibles, self pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize Advanced Urology Medical Center and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees through the services of an attorney or collection agency, I understand this will increase my balance approximately 30%.

PATIENT SIGNATURE: _____

DATE: _____



Patient's Name	Date
Who referred you to this office?	Medical Doctor/PCP
Why are you seeing the physician today?	
When did your problem start?	Pharmacy (Name & Number)

Date of Birth: _____

My Main Problems are:

- | | | | |
|--------------------------------------------|-----------------------------------------------|-----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> High PSA | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Prostate Infection | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Bladder Cancer |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Overactive Bladder | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Lump in Testicle | <input type="checkbox"/> Other: _____ | | |

Allergies:

- None
 PCN
 Sulfa
 Cipro
 Iodine/Contrast
 Other: _____

Medications (Please list all current medications):

Surgical History:

- | | | | |
|-------------------------------------------|-----------------------------------------------|--------------------------------------|------------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Back/Hip/Knee | <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Kidney Stone Surgery | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Prostate Surgery | <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> No Changes |

Medical History:

- | | | | |
|------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Other: _____ | | |

- Cancer: Prostate
 Kidney
 Testis
 No Changes

Family History:

- Prostate Cancer
 Kidney Cancer
 Kidney Stones
 Heart Disease

Social History:

- Marital Status: Single
 Married
 Divorced
 Widowed
 Smoke: No
 Yes
 Occupation: _____
 Retired

My Symptom(s) are:

- | | | | |
|---------------------------|----------------------------------------------|---------------------------------------------|----------------------------------------------|
| General/Constitutional | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Chills |
| Eyes | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Cataracts |
| Ears, Nose, Mouth, Throat | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Nasal Stuffiness | <input type="checkbox"/> Sore Throat |
| Cardiovascular | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Irregular Heartbeat |
| Respiratory | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chronic Cough |
| Gastrointestinal | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Change in Bowels |
| Genitourinary | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine |
| Musculoskeletal | <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Chronic Neck Pain | <input type="checkbox"/> Sore Muscles |
| Integumentary/Skin | <input type="checkbox"/> Rash | <input type="checkbox"/> Persistent Itching | <input type="checkbox"/> Skin Cancer History |
| Neurologic | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dizziness |
| Hematologic/Lymphatic | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Transfusion History |

Urinary Symptom(s) are:

- Incomplete Emptying
 Frequency
 Intermittency
 Weak Stream
 Straining
 Testicle Pain
 Pain in Side R / L
 Urinating at Night # _____



Patient's Name	
Date of Birth	
Age	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Occupation (or former occupation)	

Chief Complaint:

What is the main reason for your visit today? (Please describe in detail) _____

History of Present Illness:

Location of problem: Abdomen Back Genitals Other: _____	How long does the problem last? 30 minutes 1 day Always there Other: _____
On a scale of 1-10, with 10 being the most severe, circle the number that best describes your problem 1 2 3 4 5 6 7 8 9 10	Is there anything else occurring at the same time? Yes No If Yes, explain _____ Nausea Rash Headache Other: _____
When did you first notice the problem? 2 days ago 1 week ago 1 month ago Other: _____	Is the problem constant or variable? Dull, then sharp Sharp, then leaves Always there Other: _____
Does anything help or make the problem worse? Yes No Moving around Standing Eating	Does the problem interfere with your normal function? Yes No If yes, explain: _____
Physician use (comments and notes)	



HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related to health care services.

Uses and Disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.



PF-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting your office's Practice Administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Print Patient's Name

Patient MRN

Patient or Legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship to Patient

(Notation, if any, by staff)

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

Print Name of person/organization

Relationship to Patient

Print Name of person/organization

Relationship to Patient



1211 W. La Palma Ave. Ste. 502
Anaheim, CA 92801
P: 714-776-7090
F: 714-776-5632

NO SHOW POLICY

EFFECTIVE OCTOBER 01, 2012

There will be a \$25 charge for No Shows, for a missed appointment, if office is not notified 24 hours in advance of the scheduled appointment.

There will be a \$50 charge for a MISSED Procedure (e.g. Cysto, VAS, BX, Urodynamics) if office is not notified 24 hours in advance of the scheduled procedure.

*****ALL PATIENTS WILL BE CONSIDERED A NO SHOW IF THEY MISS AN APPOINTMENT AND DO NOT NOTIFY US 24 HOURS IN ADVANCE OF THE APPOINTMENT.**

Payment of the no show charge must be paid by cash, check or credit card.

I have read and understand the above No Show Policy.

Patient Signature

Date



SIGNATURE FORM

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

Patient Name: _____

MRN#: _____

Date: _____

I understand that I am financially responsible to **Advanced Urology Medical Center** for charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. I also agree that, should I fail to assume that financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of the doctor's charges. I authorize **Advanced Urology Medical Center** to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original.

Date

Signature of Patient or Guardian

**EXTENDED PAYMENT REQUEST (One Time Authorization)
(Medicare and Medicaid Patients ONLY)**

I request that payment of authorized Medicare benefits or other insurance benefits be made on my behalf to **Advanced Urology Medical Center** for any services furnished me by that provider. This one time signature will be maintained on file as verification for all subsequent services which are provided to you by this provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or other insurance carriers any information needed to determine these benefits or the benefits for related services.

Date

Signature of Patient or Guardian

**MEDIGAP AUTHORIZATION
(Medicare Patients only)**

I request that payment of authorized Medigap benefits be made on my behalf to **Advanced Urology Medical Center** for any services furnished me by that provider. I authorize any holder of medical information about me to.

Release to _____ any information needed to determine these benefits
(Name of Medigap Insurer)
Or the benefits payable for related services.

Medicare Number: _____

Secondary Insurance: _____ Policy: _____

Date

Signature of Patient or Guardian