Patient Name: _____ Date of Birth: _____ Today's Date: _____
*First Middle Initial Last*

# PACIFIC UROLOGY

100 N. WIGET LANE, SUITE 290, WALNUT CREEK, CA 94598 - (925) 937-7740, FAX (925) 933-9868
2222 EAST STREET, SUITE 250, CONCORD, CA 94520 - (925) 609-7220, FAX (925) 689-3298
5201 NORRIS CANYON RD, SUITE 140, SAN RAMON, CA 94583 - (925) 830-1140, FAX (925) 275-0454

## PATIENT INFORMATION

Please Print Clearly & Fill Out Completely

| | | |
|---|---|---|
| Last Name | First Name | Middle Initial |
| Date of Birth | Age | Social Security Number |
| Address | | |
| City | State / Zip | Email |
| Home Phone ( ) - | Cell Phone ( ) - | Work Phone ( ) - |

## PHYSICIAN INFORMATION

| | |
|---|---|
| Physician Who Referred You To Our Office | Diagnosis or Reason for Referral |
| Primary Care Physician | Physician You Are Seeing At Our Office |

## PRIMARY INSURANCE COVERAGE

| | | |
|---|---|---|
| Insurance Company Name | Insurance Care is in the Name of? ❑ Self ❑ Spouse ❑ Other _____ | |
| Complete the following information for the person whose name appears on the Insurance Card: | | |
| Name | Date of Birth | Social Security Number |
| Group # | Plan Name | |
| Policy ID # | Medical Group Name | Co-Pay $ |
| Does your insurance require a referral to see a Specialist? ❑ NO ❑ YES (If YES, please give referral slip to Receptionist) | | |

## SECONDARY INSURANCE COVERAGE

| | | |
|---|---|---|
| Insurance Company Name | Insurance Care is in the name of? ❑ Self ❑ Spouse ❑ Other _____ | |
| Complete the following information for the person whose name appears on the insurance card: | | |
| Name | Date of Birth | Social Security Number |
| Group # | Plan Name | |
| Policy ID # | Medical Group Name | Co-Pay $ |
| Does your insurance require a referral to see a Specialist? ❑ NO ❑ YES (If YES, please give referral slip to Receptionist) | | |

## EMERGENCY CONTACT

| | | |
|---|---|---|
| Name | Relationship | Phone |

## RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize my physician and Pacific Urology (PU) to submit insurance claims on my behalf. I authorize my insurance company or its carriers to disclose any information requested by my physicians regarding claims for medical services they provide me. I authorize John Muir Medical Center, San Ramon Valley Medical Center or any other hospital where I may be a patient to release information requested by PU. I authorize PU to release information to physicians referred by PU. I authorize payments of assigned medical benefits to be paid directly to my physician and PU. I am responsible for deductibles, coinsurance, and non-covered items. I agree to pay any co-payments required by my insurance plan at the time of service. I understand that Pacific Urology does not bill tertiary insurances, other than Medicare or MediCal.

| | |
|---|---|
| | |
| ***** SIGNATURE**: Patient or Legally Authorized Individual | Date |
| | |
| Print Name | If Signed on Behalf of Patient, Relationship to Patient |

Patient Name: _____ Date of Birth: _____ Today's Date: _____
*First Middle Initial Last*

## PATIENT DEMOGRAPHICS

### RACE / ETHNICITY

- ❑ Decline to Answer
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian / Pacific Islander
- ❑ White / Caucasian

### GENDER / STATUS

GENDER: ❑ Male ❑ Female

MARITAL STATUS:

- ❑ Decline to Answer
- ❑ Single
- ❑ Divorced
- ❑ Married
- ❑ Domestic Partner
- ❑ Widow
- ❑ Other

### PREFERRED LANGUAGE

- ❑ Decline to Answer
- ❑ English
- ❑ Spanish
- ❑ French
- ❑ Punjabi
- ❑ Hindi
- ❑ Sign Language - Deaf
- ❑ Vietnamese
- ❑ Chinese
- ❑ Russian
- ❑ Tagalog
- ❑ Italian
- ❑ Other

### CONTACT PREFERENCE

*Check One:*
❑ HOME ❑ CELL ❑ WORK ❑ MAIL

### OCCUPATION

Current or Previous:

### PRACTICE SELECTION

What factors helped you choose our practice for your medical care? *(Check all that apply)*

- ❑ Referred by Physician
- ❑ Hospitalist Referral
- ❑ Convenient Location
- ❑ Comprehensive Services
- ❑ Reputation of Practice
- ❑ Reputation of Physicians
- ❑ Family/Friend Recommended
- ❑ Website
- ❑ Internet Search
- ❑ News Story
- ❑ Articles in Papers
- ❑ Newspaper Ad
- ❑ Community Event
- ❑ Social Media
- ❑ Speaker Program
- ❑ Other

May we keep you informed of PU news & events via confidential Email? ❑ Yes ❑ No Email:

## PATIENT INFORMATION AUTHORIZATION – HIPAA PRIVACY

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Completion of this form tells us your preferences with regard to telephone messages and whom you give authorization for our office to speak with on your behalf. Further authorization may be needed under more specific circumstances.

### CONTACT PREFERENCE *(Check ONE):* ❑ HOME ❑ CELL ❑ WORK ❑ MAIL

Below…Please check ALL that apply:

| **HOME PHONE** | **CELL PHONE** | **WORK PHONE** | **MAIL / EMAIL / FAX** |
|---|---|---|---|
| ❑ OK to leave detailed message***** | ❑ OK to leave detailed message***** | ❑ OK to leave detailed message***** | Billing Statements & Correspondence will be mailed to your Home unless you provide alternate address: |
| ❑ Leave message with call-back number only | ❑ Leave message with call-back number only | ❑ Leave message with call-back number only | ❑ OK to contact you via Email **EMAIL:** |
| **HOME #** ( ) - | **CELL #** ( ) - | **WORK #** ( ) - | **HOME FAX #** ( ) - **WORK FAX #** ( ) - |

***** *Either with any individual, other than yourself, whom answers the phone or on an answering machine.*

### OTHER AUTHORIZED INDIVIDUALS

Other individuals I authorize to take messages or receive my Protected Health Information are:

| **NAME** *(List all that apply)* | **RELATIONSHIP TO YOU** | **CONTACT INFO** |
|---|---|---|
| | Spouse / Significant Other | Phone: ( ) - |
| | | Phone: ( ) - |
| | | Phone: ( ) - |
| | | Phone: ( ) - |

I request the following restrictions to the use or disclosure of my health information:

My signature below authorizes Pacific Urology (PU) to use my Protected Health Information per my instructions above and acknowledges that I have received PU's Notice of Privacy Practices & I consent to the use and disclosure of my health information for treatment, payment or healthcare operations.

| | |
|---|---|
| | |
| ***** SIGNATURE**: Patient or Legally Authorized Individual | Date |
| | |
| Print Name | If Signed on Behalf of Patient, Relationship to Patient |
| | |
| PU Witness Name / Signature | Date |

Patient Name: _____ Date of Birth: _____ Today's Date: _____
*First Middle Initial Last*

## FINANCIAL POLICIES

### CO-PAYMENT, DEDUCTIBLE & CO-INSURANCE COLLECTION POLICY

**We are required by law, and your health plan, to collect co-payments at the time of service.** Co-payments are required each time you are seen by the physician or nurse practitioner. This co-payment is for the limited office visit charge that covers the medical management that the physician provides in overseeing your treatment. **This policy is established by your health plan** and is explained in your benefits handbook and is usually printed on your insurance card.

It is our policy to collect coinsurance and deductibles at the time of service. Prior to any scheduled hospital procedure, any coinsurance and deductible will be collected at the time of the pre-operative visit. If you have any questions or concerns about your insurance coverage, please call your insurance carrier directly.

It is the patient or guardian's responsibility to determine if the doctor you are seeing is a contracted provider with your insurance. If required insurance cards, co-pays and/or authorizations are not provided at the time of your service, your appointment may be rescheduled.

### INSURANCE REIMBURSEMENT & BILLING POLICIES

**BILLING STATEMENT: We are happy to bill your insurance as a courtesy to you.** Each month you will receive a statement from us describing your current balance and any charges incurred during the statement month. You can submit this bill yourself, along with the appropriate forms, to your insurance carrier. Or, as many of our patients prefer, we will bill your primary and secondary insurance carrier for you. Pacific Urology does not bill tertiary insurance coverage other than Medicare or MediCal. For us to do so, you must sign the "*Release of Information & Assignment of Benefits*" statement on the first page of this packet. We will bill your insurance a maximum of three (3) times, then the responsibility for handling issues with insurance reimbursement rests with you. You are ultimately responsible for payment of your bill.

When you receive our monthly statement, payment is expected within thirty (30) days. Payments are considered delinquent after sixty (60) days. If Pacific Urology or its physicians are not contracted with your insurance carrier, you are considered a "self-pay" patient and payment is due in full at the time of service.

**ATTORNEY FEES AND COLLECTION COSTS: If any legal action is necessary to enforce or interpret the terms of these billing policies, the prevailing party shall be entitled to reasonable attorneys' fees, costs and necessary disbursements in addition to any other relief to which that party may be entitled. You agree by your signature below to pay all collection costs, including attorneys' fees on all delinquent payments.**

**SUSPENSION OF CARE (EXCEPT EMERGENCY CARE):** If no payment is received after ninety (90) days, we may be forced to suspend all but emergency care until a payment is received. Please discuss all billing issues directly with our billing department.

### ADMINISTRATIVE FEES

Due to the high volume of requests we receive, we charge administrative fees for copying of all or part of a medical record, completion of disability forms, printouts of your billing statements, and other such administrative requests. The current fee schedule (which is subject to change) is:

| | |
|---|---|
| Printing of Medical Records Fee: | $ 25.00 (extensive records will be charged at a higher rate) |
| Established Patient No-Show: | $ 25.00 |
| New Patient No-Show: | $ 50.00 |
| Reschedule of Surgery: | $100.00 |
| Disability Forms: | $ 25.00 |
| Pre-Authorization of Medications: | $ 25.00 |
| Returned Check Charge: | $ 25.00 |

My signature below indicates that I have read, understood and agreed to the Financial Policies of Pacific Urology

| | |
|---|---|
| | |
| Signature: Patient or Legally Authorized Individual | Date |
| | |
| Print Name | If Signed on Behalf of Patient, Relationship to Patient |

A copy of this page will be provided to you at your request. *Revised: 07/15/2013*

Patient Name: _____ Date of Birth: _____ Today's Date: _____
*First* *Middle Initial* *Last*

Physician Who Referred you? _____

*Some of the following questions are very personal. They are not intended to pry needlessly into your health, marital or sexual history. Each of them has a specific relationship to infertility problems.*

**MALE**

Date of Birth: _____/_____/_____
Month Day Year

Highest Level of Education: _____

Religion: _____

Ethnicity: (Check one or more) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined

**FEMALE**

Date of Birth: _____/_____/_____
Month Day Year

Highest Level of Education: _____

Religion: _____

Ethnicity: (Check one or more) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined

| **MALE MEDICAL HISTORY:** | **No** | **Yes** | **If Yes, When** |
|---|---|---|---|
| High Blood Pressure (Hypertension) | ☐ | ☐ | |
| Kidney Problems | ☐ | ☐ | |
| Infection of Prostate | ☐ | ☐ | When/Where? |
| Infection of the Testicles or Epididymis | ☐ | ☐ | |
| Blood in the Ejaculation (semen) | ☐ | ☐ | |
| Have you had an infection of your urinary tract? | ☐ | ☐ | |
| Do you urinate frequently? | ☐ | ☐ | |
| Do you have to get up at night to urinate? | ☐ | ☐ | |
| Do you ever leak urine? (incontinence) | ☐ | ☐ | |
| Have you ever had a venereal infection? (VD, gonorrhea, syphilis) | ☐ | ☐ | |
| Have you ever had white, green or yellow discharge from the end of your penis? | ☐ | ☐ | |
| Have you ever had mumps? | ☐ | ☐ | |
| a) Did it affect your testicles? | ☐ | ☐ | |
| Have you ever had any of the following? | | | |
| a) Diabetes | ☐ | ☐ | |
| b) Cancer | ☐ | ☐ | |
| c) Neurologic Disorders | ☐ | ☐ | |
| d) Radiation Therapy | ☐ | ☐ | |
| e) Heart Problems | ☐ | ☐ | |

Patient Name: _____ Date of Birth: _____ Today's Date: _____
*First Middle Initial Last*

| MALE MEDICAL HISTORY Cont.: | No | Yes | If Yes, When |
|---|---|---|---|
| Have you ever had surgery for the following? | | | |
| a) Vasectomy | ☐ | ☐ | |
| b) Varicocele (varicose vein in the scrotum) | ☐ | ☐ | |
| c) Penis Surgery | ☐ | ☐ | |
| d) Prostate Surgery | ☐ | ☐ | |
| e) Testicle Surgery | ☐ | ☐ | |
| Have you ever had a hernia surgery? | ☐ | ☐ | |
| Did you have undescended testicles at birth? | ☐ | ☐ | |
| Have you had any other surgery? | ☐ | ☐ | |
| Have you had any illness requiring hospitalization? | ☐ | ☐ | |
| a) Illness: | | | |
| b) Illness: | | | |
| c) Illness: | | | |
| Have you ever had trauma (injury) to your testicles? | ☐ | ☐ | |
| Do you frequently take hot baths, saunas, steam baths? | ☐ | ☐ | |
| Do wear jockey shorts? | ☐ | ☐ | |
| At what age did you start to shave? _____ | | | |
| a) How often do you need to shave? | _____ | | |
| b) How does your beard compare to other males? | _____ | | |
| Have you had a high fever in the past three (3) months? | ☐ | ☐ | |
| **Medication and Drugs** | **No** | **Yes** | |
| Do you smoke? | ☐ | ☐ | |
| Do you now or have you used any of the following drugs? | | | |
| a) Alcohol | ☐ | ☐ | |
| b) Marijuana | ☐ | ☐ | |
| c) Other Street Drugs | ☐ | ☐ | |
| Are you currently taking any prescribed medications? | ☐ | ☐ | |
| a) Medication: _____ Amount: _____ | | | Frequency: _____ |
| b) Medication: _____ Amount: _____ | | | Frequency: _____ |
| c) Medication: _____ Amount: _____ | | | Frequency: _____ |
| Do you have allergies? | ☐ | ☐ | |
| If yes, what medication do you take for it? _____ | | | |
| Do you have any allergies to medications? | ☐ | ☐ | |
| a) Medication:_____ | | | Reaction:_____ |
| b) Medication:_____ | | | Reaction:_____ |
| c) Medication:_____ | | | Reaction:_____ |
| Have you ever taken any steroids (Prednisone,cortisone)? | ☐ | ☐ | |
| a) Medication:_____ | | | |
| b) Medication:_____ | | | |

Patient Name: _____ Date of Birth: _____ Today's Date: _____
*First Middle Initial Last*

| **Work History** | **No** | **Yes** | |
|---|---|---|---|
| Occupation:_____ | | | |
| Have you ever been exposed to any of the following: | ☐ | ☐ | |
| a) Chemicals or solvents & fumes (Agent orange) | ☐ | ☐ | |
| b) Temperature extremes (cold or extreme heat) | ☐ | ☐ | |
| c) X-rays or radioisotopes | ☐ | ☐ | |
| d) Lead or lead products? | ☐ | ☐ | |
| Is your occupation stressful? | ☐ | ☐ | |
| Do you need to meet rigid deadlines or the time schedules? | ☐ | ☐ | |
| Do you travel frequently? | ☐ | ☐ | |
| Do you sleep well at night? | ☐ | ☐ | |
| **Sexual History** | **No** | **Yes** | |
| How frequently do you have intercourse? Times per week: _____ | | | |
| How often do you ejaculate? Times per week: _____ | | | |
| Do you obtain an erection easily? | ☐ | ☐ | |
| Do you often have erections in the morning? | ☐ | ☐ | |
| Do you maintain your erection sufficiently for intercourse? | ☐ | ☐ | |
| Have you ever ejaculated through a flaccid penis? | ☐ | ☐ | |
| Do you ever ejaculate prior to penetration for intercourse? | ☐ | ☐ | |
| Is intercourse ever painful for you? | ☐ | ☐ | |
| Is intercourse painful for your partner? | ☐ | ☐ | |
| Do you use any form of lubrication for intercourse? | ☐ | ☐ | |
| Had your partner ever used any contraceptives? | ☐ | ☐ | Type(s): |
| Is your partner subject to vaginal infections? | ☐ | ☐ | Frequency: |
| Does your partner douche immediately following intercourse? | ☐ | ☐ | |
| **History of Previous Fertility** | **No** | **Yes** | |
| How long have you and your partner been trying to have a child? _____ | | | |
| Have you and your partner had a previous child together? | ☐ | ☐ | Child's Age: |
| Has your partner ever had a miscarriage? | ☐ | ☐ | |
| Have you ever had any children with another partner? | ☐ | ☐ | How many? Age(s): |
| Have you previously been tested for fertility? | ☐ | ☐ | When: |
| a) Where: _____ | | | |
| b) Did you undergo any treatment? | ☐ | ☐ | Type: |
| Has your partner undergone any fertility evaluations? | ☐ | ☐ | |
| Has your partner ever been treated for infertility? | ☐ | ☐ | |
| Do you have intercourse every other day during ovulation? | ☐ | ☐ | |
| Does your partner use a basal body temperature chart? | ☐ | ☐ | |
| Do you understand how to use it? | ☐ | ☐ | |
| Does your partner use an ovulation kit? | ☐ | ☐ | |

Patient Name: _____ Date of Birth: _____ Today's Date: _____
*First Middle Initial Last*

| History of Previous Fertility Cont. | No | Yes | |
|---|---|---|---|
| Does your partner usually get out of bed immediately following intercourse? | ❑ | ❑ | |
| Who is your partner's physician? | | | Name: |
| Do you have any family history of infertility? | ❑ | ❑ | |

## FAMILY HISTORY

| RELATION | AGE(S) | STATE OF HEALTH | IF DECEASED, CAUSE/AGE OF DEATH |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Siblings | | | |
| Spouse | | | |
| Children | | | |
| Are you of Ashkenazi Jewish descent? | **YES** ❑ | **NO** ❑ | |

**Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.**

| Disease | Family member |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## SOCIAL HISTORY

| (✓) | SUBSTANCE: | APPROXIMATE YEAR STARTED / FREQUENCY: |
|---|---|---|
| ☐ | ALCOHOL | Year: ☐ Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always |
| ☐ | SMOKING STATUS | ❑ Current/Every Day ❑ Current/Some Days ❑ Former Smoker ❑ Never Smoker ❑ Unknown |
| ☐ | TOBACCO | Year: Pack(s) A Day: Quit: ☐ NO ☐ YES *If YES*, Date Quit: |
| ☐ | STREET DRUGS/OTHER | Year: Type: Do you use needles? ❑ YES ❑ NO |
| ☐ | HIV positive or AIDS | ☐ YES ☐ NO |

Patient Name: _____ Date of Birth: _____ Today's Date: _____
*First Middle Initial Last*

## CURRENT MEDICATION LIST

| DRUG NAME | DOSE | FREQUENCY | PRESCRIBING PHYSICIAN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## ALLERGIES

☐ None ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Cipro ☐ Macrobid

☐ Other (List All):

| MEDICATION | SPECIFIC TYPE OF REACTION |
|---|---|
| | |
| | |
| | |

## CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to Pacific Urology to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.

| | |
|---|---|
| | |
| ***** SIGNATURE**: Patient or Legally Authorized Individual | Date |
| | |
| Print Name | If Signed on Behalf of Patient, Relationship to Patient |

## PREFERRED OUTSIDE PHARMACY

**Name & Address (Location) of Preferred <u>OUTSIDE</u> Pharmacy:** **Is this is a MAIL ORDER PHARMACY? ❑ Yes ❑ No**

**Please list a local pharmacy for urgent prescriptions if primary is a mail order.**
**Name & Address/Phone of LOCAL pharmacy:**