Some Important Reminders:

1. Please have all your insurance cards and form of ID (State issued or military ID) for your appointment. **(We will not see you if you do not have your insurance cards or form of ID.)** As a reminder we are not preferred providers for the following insurances:

AETNA PPO 03/01/2002
HEALTH NET PPO 01/01/2004
ONE HEALTH PPO 10/01/2003
MULTIPLAN PPO 01/26/2006
BEECH STREET PPO 07/27/2007
PHCS PPO 09/07/2004

Private Health Care Systems (PHCS) manages a lot of different PPO' s. If you are not sure about your insurance please call your insurance to verify that they are not part of PHCS or any other insurances we are not participating with. We will continue to see patients who have the aforementioned insurances. We will be happy to bill your insurance, but you will have a higher deductible and or out-of-pocket expense. It is possible that you may not have non-participating benefits at all. If you have any questions about your coverage and/or benefits, please call your insurance and inquire about non-participating coverage.

2. Please complete **front and back** of all paperwork. **(If your paperwork is not completed, it could delay your appointment.)**

3. If you had any recent radiology tests of blood work please inform the front office. If you have had any radiology tests please bring your films with you to your visit.

PATIENT REGISTRATION FORM

PATIENT'S ACCOUNT #	GUARANTOR	CHART NUMBER	CATEGORY
NAME (LAST, FIRST INIT.)	HOME PHONE NO.	DOB	DL#
ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO.	SEX (M/F)	MARITAL STATUS	
OCCUPATION	EMPLOYER	NATURE Of BUSINESS	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER PHONE NO.	REFERRAL	IN CASE Of EMERGENCY CONTACT PERSON AND PHONE NO.	

INSURANCE INFO.

PLEASE PROVIDE COPY OF INSURANCE CARD

INSURANCE NAME & ADDRESS				
SUBSCRIBER NO.	GROUP NO.		COVERAGE FROM	COVERAGE TO
ANNUAL DEDUCTIBLE	DEDUCTIBLE MET	CO-PAYMENT	% OF COVERAGE	PAY PLAN
CLAIM NUMBER	INSURED'S NAME		INSURED'S DATE Of BIRTH	
INSURED'S SEX (M/fl	INSURED'S PHONE NO.		INSURED'S SOCIAL SECURITY NO.	
INSURED'S ADDRESS	CITY		STATE	ZIP CilOE
INSURED'S EMPLOYER			EMPLOYER'S PHONE NO.	
EMPLOYER'S ADDRESS	CITY		STATE	ZIP CODE

INSURANCE INFO.

PLEASE PROVIDE COPY Of INSURANCE CARD

INSURANCE NAME & ADDRESS				
SUBSCRIBER NO.	GROUP NO.		COVERAGE FROM	COVERAGE TO
ANNUAL DEDUCTIBLE	DEDUCTIBLE MET	CO-PAYMENT	% OF COVERAGE	PAY PLAN
CLAIM NUMBER	INSURED'S NAME		INSURED'S DATE Of BIRTH	
INSURED'S SEX (M/F)	INSURED'S PHONE NO.		INSURED'S SOCIAL SECURITY NO.	
INSURED'S ADDRESS	CITY		STATE	ZIP CODE
INSURED'S EMPLOYER			EMPLOYER'S PHONE NO.	
EMPLOYER'S ADDRESS	CITY		STATE	ZIP CODE

I authorize payment of medical benefits be made directly to the physician provider for services rendered.

DATE ______________________ SIGNED (Insured or Authorized) ______________________

I authorize any insurance company, organization, employer, hospital. physician, or pharmacist to release any information to this claim and the expenses reported.

DATE ______________________ SIGNED (Insured or Authorized) ______________________

I understand that I am responsible for all fees at time of service regardless of insurance coverage including any legal costs incurred in the collection of this account if delinquent.

Date ______________________ Signed (Insured or Authorized) ______________________

UROLOGICAL MEDICAL GROUP OF NORTH ORANGE COUNTY

Adult and Pediatric Urology

CHARLES C. STREIT, M.D" F.A.C.S.
ALAN C. WEINBERG, M.D., F.A.C.S.
MICHAEL S. GAZZANIGA, M.D., F.A.C.S.

PLEASE PRINT LEGIBLY!

PATIENT HISTORY

Date ______________________

Name ______________________

Date of Birth ______________________

Spouse/Parent Name ______________________

Emergency Phone ______________________

Reason for Visit ______________________

PAST MEDICAL HISTORY

MEDICAL DATE DATE

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Lump
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Hay fever
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ Kidney infection
- ☐ Pneumonia
- ☐ Prostate problems
- ☐ Rectal bleed
- ☐ Aheumatic fever
- ☐ Thyroid trouble
- ☐ Ulcer
- ☐ Weight loss
- ☐ Other (specify) ______________________

____

SURGERIES DATE

- ☐ Abdominal
- ☐ Appendix
- ☐ Breast
- ☐ Broken Bones
- ☐ Gall Bladder
- ☐ Hearl
- ☐ Prostate
- ☐ Tonsils
- ☐ Uterus and/or Ovary
- ☐ Other ______________________

____

Height ________

Weight ________

FAMILY HISTORY

	Age (if living)	Age at death	Cancer	Diabetes	Heart disease	High blood pressure	Stroke	Cause of death or major illness
Father								
Mother								
Grandmother								
Grandfather								
Brothers								
Sisters								

SOCIAL HISTORY (Please Circle)

Single Married Widowed Divorced Separated

Children: None 1 2 3 4 5

Occupation: ______________________

Education Level: ______________________

Do you smoke? ________ Cig. per day ________

Drink coffee? Cups per day ______________________

Alcohol (type) ______________________

Drinks per *day/wk/mo* ______________________

Race: Black Caucasian Hispanic Asian Other

Religion: ______________________

OB-GYN

Date of last Mammogram ______________________

Date of last PAP test ______________________

Interval between periods ______________ days

Duration ________ days Flow: light normal heavy

Date of last period ______________________

Pain with periods yes no duration ______________

Number of pregnancies ______________________

Number of miscarriages ______________________

MEDICATIONS	DOSE	FREQUENCY

LIST ALL DRUG ALLERGIES/SENSITIVITIES

- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Others ______________________

____

REVIEW OF SYSTEMS

PLEASE CIRCL E YES OR NOT TO ALL QUESTIONS. DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING SYSTEMS? PLEASE EXPLAIN ANY "YES" ANSWERS IN SPACE PROVIDED.

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Headache Y N
- Other___________

Eyes
- Blurred Vision Y N
- Double Vision Y N
- Pain Y N
- Other___________

Allergic/Immunologic
- Hay Fever Y N
- Drug Allergies Y N
- Other___________

Neurological
- Tremors Y N
- Dizzy Spells Y N
- Numbness/Tingling Y N
- Other___________

Endocrine
- Excessive Thirst Y N
- Too Hot / Cold Y N
- Tired / Slugglish Y N
- Other___________

Gastrointestinal
- Abdominal Pain Y N
- Nausea / Vomiting Y N
- Indigestion/Heartburn Y N
- Other___________

Cardiovascular
- Chest Pain Y N
- Varicose Veins Y N
- High Blood Pressure Y N
- Other___________

Integumentary
- Skin rash Y N
- Boils Y N
- Persistent Itch Y N
- Other___________

Musculoskeletal
- Joint Pain Y N
- Neck Pain Y N
- Back Pain Y N
- Other__________

Ear/Nose/Throat/Mouth
- Ear Infection Y N
- Sore Throat Y N
- Sinus Problems Y N
- Other__________

Genitourinary
- Urine Retention Y N
- Painful Urination Y N
- Urinary Frequency Y N
- Other__________

Respiratory
- Wheezing Y N
- Frequent Cough Y N
- Shortness of Breath Y N
- Other__________

Hematological / Lymphatic
- Swollen Glands Y N
- Clotting Problem Y N
- Other__________

Psychological
- Anxiety Y N
- Depression Y N
- Suicidal Y N
- Other___________

Physician Use Only: (Comments / Notes)

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of UROLOGICAL MEDICAL GROUP OF NORTH ORANGE COUNTY's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____

____

____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _______________________________ Date: ____________________

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship**:** _________________ Witnesses by: __________________

If the patient refuses to sign, indicate your attempt to obtain a signature below.

[ ] Patient refused to sign this Acknowledgement.
Date: ___________________ Time: ________________________
Employee Name: ____

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, ________________________, understand that as part of my health care, Urological Medical Group of North Orange County originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as;

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- the right to review the notice prior to signing this consent,
- the right to object to the use of my health information for directory purposes, and
- the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Urological Medical Group of North Orange County is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Urological Medical Group of North Orange County reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Urological Medical Group of North Orange County change their notice, they will send a copy of any revised notice to the address I provided (whether U.S. mail or, if I agree, email).

I wish to allow the following people to be provided with *my* health information upon request:

Name ______________________________ Relationship ____________________________

Name ______________________________ Relationship ____________________________

Name ______________________________ Relationship ____________________________

Name ______________________________ Relationship ____________________________

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

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the tenns of this consent.

____

Patient's Signature

____

Date

______________________________ ____________________

Patient Refusal for Consent to use PHI Witness

____________________ ____________________

Date Date

FOR OFFICE USE ONLY

[ ] Consent received by : . Date: ,

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on: _

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301 W. Bastanchury Rd.
Suite 180
Fullerton, CA 92835
(714) 870-5970

16960 E. Bastanchury Rd.,
Suite F
Yorba Linda, CA 92886
(714) 870-5970

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you received is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then selects a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.