TRI VALLEY UROLOGY
MEDICAL GROUP

Philip P. Brodak, M.D., FACS
Richard Jeffrey Conner, M.D., FACS
Monisha S. Crisell, M.D., FACS
Sreenivas N. Vemulapalli, M.D., FACS
Benjamin T. Larson, M.D
Natalie A. Nealeigh, PA-C

Account #:	**Date:**

PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Last Name:	**First Name:**		**MI:**
Street Address:			
City:	**State:**	**Zip:**	
Home #:	**Cell #:**	**Work #:**	
DOB:	**Age:**	**Sex (M/F):**	**Marital Status:**
Race: ☐ **Native American or Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian** ☐ **Other Pacific Islander** ☐ **White** ☐ **Other** ________________			
Ethnicity: ☐ **Hispanic or Latino** ☐ **Not Hispanic**	**Language:**		
Employment Status:	**Occupation:**	**Years Employed:**	
Employer's Name:	**Employer's Address:**		
Driver's License #:	**Social Security #:**		
Email Address:	**Preferred Communication Method:** ☐**Home Phone** ☐**Cell** ☐**E-Mail**		
Name of Pharmacy:	**Location:**	**Phone #:**	
Name of Referring Physician:	**Phone #:**		
Name of Primary Physician:	**Phone #:**		

SPOUSE INFORMATION
PARENT INFORMATION (IF MINOR)

Last Name:	**First Name:**		**MI:**
Address:			
Home #:	**Cell #:**	**Employer's #:**	
DOB:	**Age:**	**Sex (M/F):**	**Marital Status:**
Social Security #:	**Relationship:**		
Employer's Name & Address:			

EMERGENCY CONTACT INFORMATION

Last Name:	**First Name:**	**Relationship:**
Home #:	**Cell #:**	**Work #:**

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PATIENT REGISTRATION FORM (Continued…)

INSURANCE INFORMATION			
Primary Insurance Company:		**Secondary Insurance Company:**	
Policy ID#:	**Group #:**	**Policy ID#:**	**Group #:**
Policy Holder's Name:		**Policy Holder's Name:**	
DOB:	**Relationship:**	**DOB:**	**Relationship:**
Policy Holder's SS#:		**Policy Holder's SS#:**	

Consent for Treatment and Lifetime Authorization for Assignment of Benefits and Information Release

I hereby give consent to Tri Valley Urology Medical Group to provide whatever treatment they may deem necessary to the patient above. Insured party must sign for all claims. Dependent patients must sign, if not a minor. I authorize insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested as regards my claim. I certify that the information I provided to be true and correct. I know it is a crime to fill out this form with facts I know to be false or omit facts that are important. I assign payment directly to the providers of Tri Valley Urology Medical Group which may be due from Medicare or any other insurance company. I understand I am financially responsible to Tri Valley Urology for any non-covered insurance services.

Patient or Authorized Representative's Signature: ______________________________
Date: ______________

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Why are you coming to see the doctor today?

REVIEW OF SYSTEMS

Do you now or have you ever had any of the health problems below? Please check "Yes" or "No."

Constitutional symptoms	YES	NO	Gastrointestinal	YES	NO	Neurological (Cont.)	YES	NO
Fever			Abdominal pain			Tingling		
Chills			Indigestion			Stroke		
Tired			Heartburn			Tremors		
Fatigue			Nausea			Psychiatric	YES	NO
Night sweats			Vomiting			Anxiety		
Weight changes			Constipation			Depression		
Skin	YES	NO	Diarrhea			Endocrine	YES	NO
Rashes			Genitourinary	YES	NO	Too hot or cold		
Sores			Trouble controlling urine			Excessive thirst		
Skin cancer			Up at night to urinate			Hematological, Lymphatic	YES	NO
HEENT	YES	NO	Burning with urination			Easy bruising		
Headache			Blood in urine			Excessive bleeding		
Hoarseness			Urinary frequency			Painful or swollen lymph nodes		
Glaucoma			Urinary retention			Blood transfusion		
Blurred vision			Frequent UTI			Other:		
Neck	YES	NO	Genitalia - Men	YES	NO			
Any masses or lumps			Erection difficulties					
Neck pain			Sore on penis					
Respiratory	YES	NO	Testicular lump					
Wheezing			Penile discharge					
Cough			Genitalia - Women	YES	NO			
Shortness of breath			Vaginal discharge					
Tuberculosis			Pain with intercourse					
Breast	YES	NO	Possible pregnant					
Lumps			Musculoskeletal	YES	NO			
Pain			Back pain					
Cardiovascular	YES	NO	Joint pain					
Chest pain			Neurological	YES	NO			
High Blood Pressure			Dizziness					
Irregular Heartbeat			Numbness					

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HEALTH HISTORY FORM

PAST PERSONAL MEDICAL HISTORY:
Please indicate whether you have had any of the following medical problems:

☐ Heart Disease ☐ HTN (high blood pressure) ☐ Diabetes ☐ Asthma
☐ Bleeding/clotting problem ☐ Kidney/bladder problem ☐ Cancer ☐ Thyroid problem
☐ Other (specify): ____

FEMALES ONLY – GYNECOLOGICAL HISTORY

Are you pregnant? ☐ Yes ☐ No Number of Children: _____
Number of pregnancies: ______ Births by C-Section: _____ Vaginal Deliveries: ______
Did you breast feed your children? ☐ Yes ☐ No If yes, for how long? _______________
Last pelvic exam/PAP: ________________________________
Have you had a hysterectomy? ☐ Yes ☐ No If yes, when and for what reason?
____
____
____

ALLERGIES or REACTIONS TO MEDICINES, FOODS, OTHER

Medicines	Reaction or Side effects

FAMILY HISTORY: Please list any medical problems (i.e. diabetes, hypertension, heart disease, cancer, stroke, etc.) members of your family have had.

Father	
Mother	
Siblings	

SOCIAL HISTORY

Alcohol: ☐ None Number of drinks per week _____
Cigarettes: ☐ None Packs daily _____ Years smoked ____ Year quit ______

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HEALTH HISTORY FORM (Continued…)

MEDICATION: Prescription and non prescription medicines, vitamins, herbs

Name	Dose	Frequency	Name	Dose	Frequency

Please attach list of additional medications

PAST SURGICAL HISTORY

Please list all operations you have had	Date

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CANCER HISTORY FORM

CANCER OPERATIONS, INCLUDING BIOPSIES

Type of Operation	Date

Chemotherapy: □ Yes □ No
If yes, date started: ______________________ Date completed: _________________________

Briefly describe any symptoms you feel may be related to you cancer:

____
____
____

Past Cancer History: □ Yes □ No
If yes, please describe:

____
____
____

History of Previous Radiation Therapy: □ Yes □ No
If yes, please list approximate date(s) and body area treated:

Body area treated with Radiation Therapy	Date

Family History of Cancer: □ Yes □ No
If yes, please describe which family member(s) and what type(s) of cancer:

Family Member	Cancer Type

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CONSENT FOR VERBAL RELEASE OF MEDICAL INFORMATION

□ I authorize the release of my medical information, i.e. blood test results, x-ray reports, pathology reports, etc., to my immediate family, care giver, pharmacist and any physician who participates in my care.

Name: ____

□ I authorize general messages (i.e. x-ray and lab results, appointment reminders, etc.) to be left on my answering machine or voicemail.

□ I do not authorize any information to be given to anyone other than myself.

Please tell us with whom we may discuss your medical information and treatment if you are not available.

1. ______________________________________ Relationship ________________________

2. ______________________________________ Relationship ________________________

3. ______________________________________ Relationship ________________________

Patient's Name:____ Date: ________________

Patient or Guardian's Signature: ____

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Acknowledgement of Offer of Notice of Privacy Practices

Privacy Officer: Rachelle Nicklas, MHA – (951)698-1901 ext. 206

I hereby acknowledge that I have been offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available in the reception area and that additional copies are available to me upon my request.

Printed Name: ______________________________

Signature: ______________________________

Date: ______________________________

Telephone: ______________________________

If not signed by the patient, please indicate relationship:

- ☐ **Parent or guardian of minor patient**
- ☐ **Guardian or conservator of an incompetent patient**
- ☐ **Beneficiary or personal representative of deceased patient**

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FINANCIAL POLICY FOR PATIENT CARE SERVICES

To help us provide the most efficient and reasonable health care services, it is necessary for Tri Valley Urology to have a Financial Policy stating our requirements for payment of services provided to our patients. Patients are responsible for the payment of all services provided by our office. It is our policy to bill your insurance as a courtesy to you if we have accurate and complete insurance information. The balance due is still your responsibility if we have not received payment from the insurance company within 30 days. If we receive duplicate payment from the insurance company, we will then prepare a refund for any overpayment and send it to you.

If you have insurance and we file with your carrier, we ask you pay ahead of time on the balance which is your responsibility according to your plan, (i.e. any deductible, co-pay, coinsurance amounts). For Medicare patients, we will wait until we have received payment and then bill the patient for any remaining balance due. Since we are not a party to the agreement between you and your insurance company, we ask that you assist us in contacting them in the event that services are not paid within 45 days.

If you do not have insurance and are not covered by Medicare, you will be considered a "Self Pay" patient. Payment is due in full at the time of service. This assists us in cutting down on billing and operating expenses.

Patient "No Shows" or last minute cancellations are disruptive to our practice and a tremendous loss. Please help our office reduce those losses by cancelling within 24 hours if you cannot keep your appointment. <u>Failure to give notice 24 hours prior to your appointment will result in a $25 fee to be paid by the patient.</u>

We ask that you read this policy and aid us in keeping our costs down by ensuring that we are able to be reimbursed for our services on a timely basis. We welcome the opportunity to discuss any aspects of our financial policy.

To help in this policy we ask that you assist by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date.
2. Make payments at the time of services for the entire balance if you are a "Self Pay" patient or the amount of any deductible, co-pays that may be due.
3. Discuss your account balance only with the check-out or billing staff. Please do not discuss the financial aspects of your care with the physician(s). It is important for them to be allowed to practice medicine and provide patient care. Please work with the rest of the office staff on any account questions or problems you may have. If they cannot help you or answer your questions to your satisfaction, then please, do not hesitate to contact the office manager.

________________________ ________ ____________________________________

Patient Signature Date Staff Signature

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (PSA and Cystoscopy exams). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her, the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

____________________ ________ ____________________

Patient Signature Date Physician Signature