Simi-San Fernando Valley Urology Associates
Patient Registration Form

First Name	MI	Last Name
Date of Birth	Age	Social Security Number
Address		
City	State	Zip
Email Address	Sex: ☐ Male ☐ Female	

Home Number: (______) _______- ___________**Cell Phone**: (______) _______- ___________**Work**: (______) _______- __________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Ethnicity: ____ **Preferred Language**: __________________________

If the patient is a child, lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other ____

Name of the Person (**With whom the child lives with**): ____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Social Security #: _________- _______- ____________**Responsible Party Name:** ____

Address: ____

City: ____ **State**: __________ **Zip**: ________________

Home Number: (______) _______- ___________**Cell Phone**: (_____) _______- ____________ **Work:** (______) ______- ___________

Date of Birth: ______/ ______/ _______ **Sex:** ☐ Male ☐ Female **Relationship**: ____

PATIENT EMPLOYER INFORMATION

Employed: ☐ Yes ☐ No **Student**: ☐ Full-Time ☐ Part-Time

Employer/ School Name: ____ **Address**: ____________________________________

City: ____ **State**: __________ **Zip**: ________________

Main Office Phone: (_______) ________- ______________**Occupation**: ____

IN CASE OF EMERGENCY

Relative/Friend: ____ Relationship: __________________________

Home Number: (______) _________- ______________ Cell Number: (______) _______- ______________________

REFERRING PHYSICIAN: ____Phone: (______) _______- ___________

PHARMACY NAME: ____Phone: (______) _______- __

Pharmacy Address: ____

The above information is true to the best of my knowledge; I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for my services/balance. I also authorize Simi-San Fernando Valley Urology Associates or insurance company to release any information required to process my claims.

PATIENT SIGNATURE: ____ **DATE:** ______/ _______/ ___________

Simi-San Fernando Valley Urology Associates

Patient Name: ____________________________, ______________________________ Date: _______/ _______/ __________

Why are you seeing the physician today? ____

____

When did your problem start? ____

My Main Problems are:

☐ Blood in Urine ☐ Bladder Infection ☐ Overactive Bladder ☐ Urinary Frequency
☐ Kidney Stones ☐ Urinary Incontinence ☐ Bladder Pain ☐ Dropped Bladder
☐ Bladder Cancer ☐ Other ____
☐ Interstitial Cystitis

Allergies: ☐ None ☐ PCN ☐ Sulfa ☐ Cipro ☐ Iodine/ Contrast
☐ Other____

Medications: ☐ None ☐ Aspirin ☐ Lortab ☐ Vesicare ☐ Coumadin ☐ Flomax
☐ Percocet ☐ Detrol LA ☐ Nitroglycerin ☐ Plavix ☐ Allopurinol
☐ Antibiotic: _______________________________ ☐ Other: ______________________________________

Surgical History:

☐ Heart Bypass ☐ Kidney Stone ☐ Lithotripsy ☐ C-Section #_________
☐ Sling (TVT) ☐ Hysterectomy ☐ Cystoscopy ☐ Gallbladder
☐ Appendectomy ☐ Back/Hip/Knee ☐ Vaginal Delivery
☐ Other ____

Medical History:

☐ Hepatitis ☐ Hypertension ☐ Heart Attack ☐ Heart Murmur
☐ Diabetes ☐ Hernia ☐ Parkinson's ☐ Strokes

Cancer: ____Other:____

Family History: ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease
Family Member: ____

Social History:

Smoke: ☐ Yes ☐ No **Drink Alcohol**: ☐ Yes ☐ No **How Many Caffeinated Drinks per Day**: ________

My Symptom (s):

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

Urinary Symptom (s):

☐ Incomplete Bladder Emptying ☐ Urgency ☐ Pain in Side R/L ☐ Urinary at Night # ____
☐ Frequency ☐ Abdominal Pain ☐ Bladder Pain

- ☐ Leakage

Simi-San Fernando Valley Urology Associates

PF-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep 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 the office's Practice Administrator.

Our notice of privacy practices describes in more detail how your health information may be used and how you can access your information.

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

Print Patients Name	Date of Birth
Patient or Legally Authorized Individual Signature	Date
Print Name if Signed on Behalf of 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

Print Name of Person/ Organization Relationship to Patient

Simi-San Fernando Valley Urology Associates

Patient Name: ____

Social Security Number: ______________- _________- _________________

Date of Birth: _______/ _______/ ____________

DISCLAIMER

Professional fees are due at the time the services are rendered. These include but are not limited to co-pays, deductibles, self-pay and all discount plan payments. If unable to pay your co-pay at the time of service an administrative fee of $10.00 will be assessed.

I understand that I will be responsible for all balances that are not covered by my insurance plans, to include but not limited to co-insurance, non-covered services and the total balances in the event my insurance coverage is inactive at the time of the service.

I also agree that if it becomes necessary to collect fees through the services of an attorney or collection agency. Their fees will be added to my balance. This will increase your balance by approximately 30%.

Simi-San Fernando Valley Urology Associates reserves the right to charge a fee of $50.00 for all missed appointments "No Shows" which, absent a compelling reason, are not cancelled with a 24 hour advance notice. "No Show" fees will be billed directly to the patient.

Surgery cancellations that are within 72 hours of procedure will be assessed a $150.00 cancellation fee payable by the patient.

Patient Signature: ____ Date: _______/ _______/ _______