***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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_

Address (Main Cross Streets if unknown): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you worked with metal or employed as a welder? Yes\_\_\_\_\_ No\_\_\_\_\_

**My Main Problems are:**

* Enlarged Prostate
* Kidney Stones
* Prostate Cancer
* Lump in Testicle
* High PSA
* Urinary Incontinence
* Other
* Overactive Bladder
* Bladder Infection
* Bladder Cancer
* Infertility

**Allergies:**  None PCN Sulfa Cipro Iodine/ Contrast

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:**  None Aspirin Avodart Cardura Coumadin Flomax

Hytrin Lupron Nitroglycerin Plavix Proscar Uroxatrol

Vesicare Viagra Cialis Levitra Zoladex

* Antibiotic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History:**

* Heart Bypass
* Prostate Surgery
* Appendectomy
* Kidney Stone
* Surgery
* Back/Hip/Knee
* Lithotripsy
* Cystoscopy
* Prostate Seeds
* Prostate Biopsy
* Gallbladder
* Other

**Medical History:**

* Hepatitis
* Diabetes
* Hypertension
* Hernia
* Heart Attack
* Parkinson’s
* Heart Murmur
* Strokes

**Cancer:**  Prostate Kidney Testis Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**  Prostate Cancer 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
* Testicle Pain
* Frequency
* Pain in Side R/L
* Intermittency
* Urinary at Night # \_\_\_\_
* Weak Stream
* Straining

***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

***Simi-San Fernando Valley Urology Associates***

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 from procedure will be assessed a $150.00 cancellation fee payable by the patient.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/ \_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_