

ORANGE COUNTY UROLOGY ASSOCIATES, INC.
A Medical Group

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Patient Name: _____ Birth Date: _____
Last First MI

Sex: (circle one) M F Social Security # _____ Drivers License# _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

E-mail Address _____

Preferred means of communication (circle one) Cell Phone Home Phone Email USPS Mail Any None

Primary Physician _____

Referring Physician _____

Marital Status (Circle one) S M D W

Spouse's Name _____

Spouse Phone# _____

Employer _____

Occupation _____

Pharmacy Name _____

Phone # _____

Pharmacy (Street, City) _____

Emergency Contact (other than spouse) _____

Relationship to you _____ Phone # _____

Race (circle one) • African-American/Black • Asian • Asian/Pacific Islander • Chinese
• Korean • Native Hawaiian • Native American/Alaskan Native • Vietnamese
• White • Other _____ • Decline to State

Ethnicity (circle one) • Hispanic/Latino • Non-Hispanic/Non-Latino

Language Choice (circle one) • English • Spanish • Chinese • Tagalog • Vietnamese • Korean • Farsi Other _____

RESPONSIBLE PARTY –If other than self or you are a minor.

Name: _____ Relationship: _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ S.S. # _____

MEDICAL INSURANCE (please present insurance cards for us to photocopy)

Primary Insurance Company: _____ Subscriber's Name _____

Subscriber's Relationship to Patient _____

Insured's ID# _____ Group # _____ Medicare # _____

Secondary Insurance Company: _____ Subscriber's Name _____

Subscriber's Relationship to Patient _____

Insured's ID# _____ Group # _____ Medicare # _____

PLEASE BE ADVISED THAT YOU WILL RECEIVE SEPARATE BILLS FOR ANY LAB TESTS, X-RAYS, ETC. THAT MAY BE ORDERED FOR YOU, AS THEY ARE DONE BY AN OUTSIDE SOURCE.

Assignment of Benefit-Financial Agreement

Assignment and Release. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I hereby assign my benefits to be paid directly to my physician and any assisting physicians. I understand a monthly service fee will be charged on all balance 61 days and older. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I authorize this provider to release any information required to process this claim to my insurance company.

Date: _____ Your Signature X _____

THANK YOU FOR YOUR CAREFUL COMPLETION OF THIS IMPORTANT FORM

Revised 8/22/14

ORANGE COUNTY UROLOGY ASSOCIATES, INC.

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PF-2000 Acknowledgement of Receipt of Notice of Patient Privacy

Orange County Urology Associates, Inc. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practice of Orange County Urology Associates, Inc.

Signature of Patient

Name of Patient (Please Print)

Date

Patient Date of Birth

Preferred/Secure Phone Options: Yes No

If yes, Please provide a phone number in which we may leave a message on your voicemail with your personal health information. Home Cell Work

Phone#: _____

Authorized Email Address: To facilitate communication between OCUA and our patients, I give permission to use my email address in a secure online environment. The email communication will be through secure, encrypted messaging. I understand the email address I provide will be used primarily for accessing my patient portal on the OCUA website at www.orangecountyurology.com. It will also be used to contact me for future appointment reminders. Unless I inform OCUA that my email address has changed, OCUA has permission to use the email address below. OCUA will not share this address with any other entity.

Email Address: (Please print clearly) _____

Expanded Medical Release Option:

Please note: This is Valid for 1 Year

Please list any person(s) you would like to authorize to have access to your billing, appointments or health information.

*** Such as a Spouse, Parents, Family Members, and/or Friends.*

*** With the exclusion of information that is protected under State or Federal law*

Name

Relationship

Signature of Patient/Representative

Relationship of Patient Representative

*** Please note that State Federal law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor*

Orange County Urology Associates, Inc.
Financial Policy

Welcome to Orange County Urology Associates, Inc. Your initial visit can range from \$200 to \$500. Here are some guidelines to help you get your insurance information ready for your visit:

MEDICARE

- Do you have a supplemental plan?
 - YES – We will bill both insurances on your behalf. You will be billed for any balance owed by you after the insurances have paid their amounts.
 - NO –
 - i. Have you met your deductible? If not; (2014: \$147 Part B)
 - ii. You will be required to pay your co-insurance percentage and any portion of the deductible that has not been met at check in.

PPO PLAN

- You will be expected to pay your share of cost at check in.
 - This will include any office services including drugs
- Are we contracted with your insurance company?
 - YES – You will be required to pay your co-payment and/or deductible at check in.
 - NO – You will be required to pay in full at check in.
- Do you have a SECONDARY INSURANCE?
 - YES – You will be required to pay your co-payment and co-insurance amounts at check in. We will bill your secondary insurance; if we receive payment we will reimburse you any excess amounts.
- You may receive charges from an outside laboratory. These charges were incurred because the tests were necessary to diagnose and/or treat your condition.
- We will bill your insurance(s) as a courtesy. Payments received in excess of your account balance will be refunded to you.

HMO, EPO, POS OR MANAGED CARE PLANS

- Has your primary care physician AUTHORIZED your visit?
 - Visits with prior approval. If your plan requires a co-payment, you will be required to pay at check in.
 - Visits without prior approval. You will be required to pay in full at check in.

You will be required to PAY IN FULL at check in if;

- You are **OUT OF NETWORK**
- You have **NO INSURANCE**
- We are **NOT CONTRACTED WITH YOUR INSURANCE**

We recommend that you verify your benefits with your insurance plan prior to your visit.

IF YOU FAIL TO PROVIDE COMPLETE, UP-TO-DATE, ACCURATE INSURANCE INFORMATION

- You will be considered a **CASH** patient and will be **required to pay in full** at check in.
- OCUA will not be responsible for billing insurance for this date of service retroactively

Effective May 1, 2009 the Federal Trade Commission (FTC) has implemented a new regulation known as the Red Flag Rule requiring physicians to develop and implement identity theft detection and prevention programs. **TO PROTECT YOU AGAINST IDENTITY THEFT** we are required to ask for a photo ID, and a second type of identification.

**I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY FOR
ORANGE COUNTY UROLOGY ASSOCIATES, INC.**

Print Name

Signature

Date

Point of Service Option

We understand you have the ability to use a Point of Service (**POS**) or HMO option. Orange County Urology Associates, Inc. holds contracts with several HMO groups. If we hold a contract it is best for you to take advantage of your HMO option, this will decrease your out of pocket expense.

If you choose to use your POS option Orange County Urology Associates, Inc. will collect your entire out of pocket expenses.

Please be aware if you choose the POS option your plan may not allow you to switch over to the HMO option for your future care.

Print Name

Sign Name

OCUA Signature

Date

Orange County Urology Associates - New Patient Information Form (Female)

Name: _____ Today's Date: _____

Age _____ Date of Birth: _____ Who referred you? _____

Office Use Only	
Date	ROS by

Present Illness

In your own words, what medical problem or concern brings you to our office today?

For how long? _____ Degree of Severity 0 1 2 3 4 5 6 7 8 9 10

Current Urinary Symptoms:

- Bladder infections
- Burning with urination
- Kidney infections/pyelonephritis
- Flank Pain
- Fever/Chills
- Urethral discharge
- Vaginitis
- Blood in urine

GYN/Obstetric History

Number of pregnancies? _____
 Number of vaginal deliveries? _____
 Number of C-sections? _____
 Number of miscarriages? _____
 Number of Stillborn? _____
 Number of voluntary terminations? _____
 Largest birth weight _____ lbs _____ oz

Prior Urological History:

- Weak or slow stream
- How often do you urinate?
 _____ Times per day _____ Times at night
- Incontinence(leakage)
 - with urge
 - with cough or sneeze
 - Number of pads used per day? _____
- Kidney stones
- Urethral Stricture
- History of sexually transmitted diseases
- Family history of kidney stones?
 Whom? _____
- Family history of cancer? Whom? _____
- IVP /CT Scan / Ultrasound / Cystoscopy exam

- Episiotomy? Yes
- Vaginal tear requiring surgery? Yes
- Forceps delivery? Yes
- Hysterectomy with ovary removal? Yes
- Hysterectomy without ovary removal? Yes
- Tubal ligation? Yes
- Ovary removal? Yes
- Laparoscopy procedure? Yes
- Date of last menstrual period? ____/____/____
- Current form of birth control? _____
- Vaginal Discharge
- Infertility

Please answer the following questions:	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	
How often do you urinate again less than 2 hours after a prior urination?	0	1	2	3	4	5	F Freq
How often do you find it difficult to postpone urination?	0	1	2	3	4	5	U Urge
How often do you have a weak urination stream?	0	1	2	3	4	5	↓ Stream
How often do you push or strain to begin urination?	0	1	2	3	4	5	S Strain
How often do you find that you stop and start again when you urinate?	0	1	2	3	4	5	I Interm
How often do you have a sensation of not emptying your bladder after urination?	0	1	2	3	4	5	PVR
How many times do you typically get up to urinate when you go to bed at night?	None	1 time	2 times	3 times	4 times	5 +	N Next

Quality of Life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed, equally satisfied and dissatisfied	Mostly Dissatisfied	Unhappy	Terrible
How would you feel about spending the rest of your life with your urinary condition just the way it is now?	0	1	2	3	4	5	6

Current Medications: Please list the medication you are currently taking and the dosage if you know it. Exclude vitamins or other supplements but include over the counter medications you take regularly.

<i>Name of Medication</i>	<i>Dose</i>	<i>Times per Day</i>	<i>Name of Medication</i>	<i>Dose</i>	<i>Times per Day</i>

Allergies **NO KNOWN DRUG ALLERGIES**

List medications to which you are allergic.

Drug Name: _____

Drug Name: _____

Please describe the reaction.

Allergic Reaction: _____

Allergic Reaction: _____

Are you allergic to latex? Yes No

Have you had an allergic reaction to Yes No

IVP dye, iodine, or x-ray contrast?

Do you require antibiotics to see your dentist? Yes No

Do you have **sleep apnea**? Yes No

Review of Past Medical History Please check previous health problems in the past or active problems at this time.
All conditions should be marked with Yes or No.

<p>Yes No Eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Retinal detachment</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>	<p>Yes No Neurological/Orthopedic</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Carpal tunnel</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Fracture</p> <p>List bones: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic migraine/ headache</p> <p><input type="checkbox"/> <input type="checkbox"/> Spinal disc disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>	<p>Yes No Cardiovascular</p> <p><input type="checkbox"/> <input type="checkbox"/> Congestive heart failure</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Elevated Cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> Rhythm disturbances, irregular heartbeat. List what kind _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Hypertension, high blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Aneurysm</p> <p><input type="checkbox"/> <input type="checkbox"/> Aortic valve problem</p> <p><input type="checkbox"/> <input type="checkbox"/> Mitral valve problem</p> <p><input type="checkbox"/> <input type="checkbox"/> Peripheral vascular problem</p>
<p>Yes No Ears, Nose, Throat</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergic rhinitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck mass</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinusitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>	<p>Yes No Liver</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p>	<p>Yes No Psychiatric</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Bipolar Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>
<p>Yes No Pulmonary</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic obstructive lung</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema from smoking</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> <input type="checkbox"/> Pulmonary Edema</p> <p><input type="checkbox"/> <input type="checkbox"/> Pulmonary Embolism</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep Apnea</p>	<p>Yes No Gastrointestinal</p> <p><input type="checkbox"/> <input type="checkbox"/> Polyps</p> <p><input type="checkbox"/> <input type="checkbox"/> Crohn's disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Small bowel obstruction</p> <p><input type="checkbox"/> <input type="checkbox"/> Diverticulitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Peptic Ulcer</p> <p><input type="checkbox"/> <input type="checkbox"/> Gallstone</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p>	<p>Yes No Skin</p> <p><input type="checkbox"/> <input type="checkbox"/> Skin cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>
<p>Yes No Endocrine</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid problem</p>	<p>Yes No Breast Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal mammogram</p> <p><input type="checkbox"/> <input type="checkbox"/> Benign breast disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p>	<p>Cancers</p> <p>List any cancers you have had:</p> <p>_____</p> <p>_____</p>
<p>Yes No Blood disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Clotting problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Leukemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Lymphoma</p>		

Surgical History. Review this list of surgical procedures. Mark those you have had and write your age or the approximate year of the surgery.

Head and Neck

- | Yes | No | Year | |
|--------------------------|--------------------------|-------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Cataracts and Lens Implant |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Nasal Septum |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Laser eye surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Thyroidectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Tonsils and Adenoids |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

Cardiovascular/Thoracic

- | Yes | No | Year | |
|--------------------------|--------------------------|-------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Abdominal Aneurysm surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Angioplasty |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Bypass surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Heart valve replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Cardiac stent |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Carotid artery |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Defibrillator implant |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Lung resection |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Peripheral vascular procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Vein stripping |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

General/Gastrointestinal

- | Yes | No | Year | |
|--------------------------|--------------------------|-------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Appendectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Bowel Resection Small |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Breast biopsy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Breast removal- mastectomy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Gallbladder removed (Open) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Gallbladder removed (Lap) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Colon Resection |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Gastrectomy (stomach removal) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hemorrhoid procedure |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hernia repair – umbilical |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

Family history

Deceased relation	Age at death	Cause of death	Living relation	Age	Illness

Orthopedic/Neurosurgical

- | Yes | No | Year | |
|--------------------------|--------------------------|-------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Arthroscopy - knee |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Arthroscopy - shoulder |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Carpal tunnel repair |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Craniotomy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Fracture – surgical repair |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Fracture – closed treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Laminectomy (spine) cervical |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Laminectomy (spine) lumbar |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Total hip replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Total knee replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other |

Plastic/Reconstructive

- | Yes | No | Year | |
|--------------------------|--------------------------|-------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Breast augmentation/implant |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Breast reduction |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Cosmetic |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Hand procedure or repair |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Rhinoplasty |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Skin tag or lesion |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

Urologic

- | Yes | No | Year | |
|--------------------------|--------------------------|-------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Bladder tumor-transurethral |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Urethral injections |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Kidney stone – removal with scope |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Urethral injections |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Kidney stone – lithotripsy |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Kidney stone – open |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | Other: _____ |

Social History

Occupation? _____

If retired, former occupation? _____

Marital status (optional) Married Widowed Divorced Single

Number of children? _____ Ages? _____

Smoking Classification

- Never smoked
- Current smoker
- Ex-smoker

How many years? _____ Packs/day _____

How many years? _____ Packs/day _____

What year did you quit? _____

Alcohol Classification

- Never drank
- Quit
- Current Drinker

Year you quit _____

Amount you drink Beer _____ ounces or 6 packs/week

Wine _____ ounces or liters/week

Liquor _____ ounces week

Social Drug Use

- Never used
- Past or current usage: *describe* _____

Current Review of Systems: Please check any *active* problems at this time.

Yes No **Constitutional**

- Fever
- Chills
- Fatigue
- Weight loss
- Loss of appetite

Yes No **Eyes**

- Poor vision
- Blurry vision
- Double vision

Yes No **Ears**

- Hearing loss
- Ringing in ears

Yes No **Nose**

- Nose bleeds
- Nasal obstruction

Yes No **Throat, Mouth**

- Sore throat
- Dentures

Other: _____

Yes No **Cardiovascular**

- Chest pain/angina
- Palpitations
- Swelling of feet/ankles
- Shortness of breath/activity
- Trouble sleeping w/1 pillow

Other: _____

Yes No **Respiratory**

- Cough
- Shortness of breath
- Wheezing

Other: _____

Yes No **Gastrointestinal**

- Jaundice
- Abdominal pain
- Diarrhea
- Nausea/Vomiting
- Bloody or black stools
- Constipation
- Pancreatitis
- Peptic ulcers

Other: _____

Yes No **Musculoskeletal**

- Backache
- Joint pain
- Muscle aches

Other: _____

Yes No **Neurological**

- Tremors
- Numbness
- Dizziness
- Headaches
- Fainting

Yes No **Psychiatric**

- Nervousness
- Hallucinations
- Anxiety
- Depression

Yes No **Endocrine**

- Hot flashes
- Excessive thirst/sweating
- Hot or cold intolerance

Other: _____

Yes No **Skin**

- Sores
- Rash
- Itching

Other: _____

Yes No **Hematologic/Lymphatic**

- Easy bruising/bleeding
- Swollen lymph nodes/glands

Other: _____

Yes No **Allergic/Immunologic**

- Rash
- Hives

Other: _____