Palm Springs Urology
555 E. Tachevah Dr. Suite 2W-101 Palm Springs, CA 92262
T: (760) 320-6005 F: (760) 323-5786

PATIENT HISTORY AND REVIEW OF SYSTEMS

DATE:	MARITAL STATUS:
NAME:	CHILDREN: BOY_____ GIRL_____
DOB: Male ___ Female ___	EDUCATION: GRADE:
PHONE: HOME- CELL-	SLEEP: HOUR(S)
EMAIL:	EXERCISE:
REFERRING PHYSICIAN:	HEIGHT: WEIGHT:
WHAT IS THE REASON FOR YOUR VISIT?	AVERAGE PER DAY:
	ALCOHOL (TYPE) HOW MUCH?:
	QUIT:
	TOBACCO: HOW MUCH?:
PAST MEDICAL HISTORY:	QUIT:
	HISTORY OF DIABETES:
	TEA, CAFFEINE:
	RACE: ASIAN AMERICAN INDIAN ALASKA NATIVE
	AFRICAN AMERICAN HISPANIC/LATINO UNKNOWN/DECLINE
PAST SURGICAL HISTORY:	LIST OF ALLERGIES:
	ANY BLOOD THINNERS OR BABY ASPIRIN? IF YES, PLEASE LIST:
FAMILY HISTORY:	PHARMACY:
	NAME:
	ADDRESS:

PATIENT INFORMATION	
LAST NAME:	HOME PHONE:
FIRST:	CELL PHONE:
MIDDLE INITIAL:	EMAIL:
DOB:	CONTACT PREFERENCE: ___ HOME ___ CELL
GENDER:	
MARITAL STATUS:	OCCUPATION:
	EMPLOYER:
DRIVER LICENSE:	WORK PHONE:
SOCIAL SECURITY:	
	EMERGENCY CONTACT:
ADDRESS:	RELATIONSHIP:
CITY:	PHONE NUMBER:
STATE:	
ZIP CODE:	***How did you hear about us/ were referred to us?***
INSURANCE INFORMATION	
PRIMARY INSURANCE	*SECONDARY INSURANCE*
INSURANCE NAME:	INSURANCE NAME:
ADDRESS:	ADDRESS:
PHONE:	PHONE:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
SUBSCRIBER #:	SUBSCRIBER #:
GROUP #:	GROUP #:
SUBS DOB:	SUBS DOB:
PATIENT'S RELATION TO SUBSCRIBER:	PATIENT'S RELATION TO SUBSCRIBER:

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 any balance. I also authorize The Urology Center of Southern California Medical Group or insurance company to release any information required to process my claim.

Patient/ Guardian Signature: _____ Date: _____

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NAME: _____ DOB: _____ DATE: _____

MEDICATION ALLERGIES:_____

ANY BLOOD THINNERS OR BABY ASPIRIN? IF YES, PLEASE LIST: _____

PHARMACY: _____ PHONE: _____

ADDRESS: _____

MEDICATION	STRENGTH	HOW OFTEN	REASON

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NAME: _____

DOB: _____

PATIENT HISTORY AND REVIEW OF SYSTEM

Have you recently had the following: circle 'yes' or 'no': If in doubt, leave blank.

GENERAL			**GENITOURINARY SYSTEM**		
Tire easily, weakness	YES	NO	Increase in frequency of urination during the day	YES	NO
Persistent fever	YES	NO	Increase in frequency of urination during the night	YES	NO
SKIN			Feel the need to urinate without much urine	YES	NO
Eruptions (rash)	YES	NO	Slow stream	YES	NO
Change in color	YES	NO	Hesitancy	YES	NO
EARS			Incomplete voiding	YES	NO
Loss of Hearing	YES	NO	Pain or burning	YES	NO
EYES			Blood in urine	YES	NO
Trouble Seeing	YES	NO	Urinary retention	YES	NO
Eye Pain	YES	NO	Urgency	YES	NO
NOSE			Urge incontinence	YES	NO
Loss of Smell	YES	NO	Leaking urine when coughing or sneezing	YES	NO
Nosebleeds	YES	NO	Do you use urinary incontinence products? If yes, how many per day _____	YES	NO
MOUTH			Urethral Discharge	YES	NO
Dental Problem	YES	NO	Vaginal Discharge	YES	NO
THROAT			Pain at the tip of the penis	YES	NO
Hoarseness	YES	NO	Testicular pain	YES	NO
CARDIO-RESPIRATORY SYSTEM			Lump in testicles	YES	NO
Cough, Persistent	YES	NO	Impotence	YES	NO

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RESPIRATORY			Lack of sex drive	YES	NO
Shortness of Breath	YES	NO	Pain with intercourse	YES	NO
CARDIAC					
Chest pain or discomfort	YES	NO			
Palpitations	YES	NO			
GASTRO-INTESTINALSYSTEM					
Nausea	YES	NO			
Vomiting	YES	NO			
MUSCULO-SKELETAL					
Muscle weakness	YES	NO			
Joint pain	YES	NO			
NERVOUS SYSTEM					
Headaches	YES	NO			
Dizziness	YES	NO			
INFECTIOUS DISEASE					
Hepatitis	YES	NO			
HIV	YES	NO			

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Patient Communication Consent

Patient Name (Last, First, Middle Initial):

_____

Date of Birth: _____

I authorize Palm Springs Urology Medical Group and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below.

Name	Relationship to Patient	Contact Information

By my signature below, I acknowledge that I have read and understand the information provided on this consent form.

Patient Name: _____

Patient Signature: _____

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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, Palm Springs Urology Medical Group 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 the Notice of Privacy Policies 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 Palm Springs Urology Medical Group 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 taken 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 Palm Springs Urology Medical Group 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 Palm Springs Urology Medical Group MD change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

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 protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax. I fully understand and accept/decline the terms of this consent.Patient's Signature _____
Date_____

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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 (mammogram, immunizations, pap smears etc). **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 Name: _____ DOB: _____

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date

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Acknowledgement of Receipt of the Notice of Privacy Practices

I hereby acknowledge that I have read and received a copy of the Notice of Privacy Practices, with an effective date of _____

Patient Name:_____ Date of Birth:_____

Signed:_____ Date:_____

Telephone: _____

Patient Address:_____

If not signed by the patient, please indicate name and relationship:

Name:_____

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Other authorized personal representative:_____

FOR INTERNAL USE ONLY

Our office has been unable to obtain a signed acknowledgement of receipt for the following reasons:

- ☐ Patient was unable to sign
- ☐ Patient / Personal representative refused to sign on _____
  Date of Refusal
- ☐ Other:_____