San Antonio Urology

1175 E. Arrow Hwy. Ste. E
Upland, CA 91876

Patient Name:______________________________ Age_____ Birth Date:________ Sex: ☐M ☐F
Last First MI

Address______________________________ City________________ State________ Zip______

☐Single ☐Married ☐Widowed ☐Divorced ☐E-mail Address ______________________________

☐Home Phone________________ ☐Cell Phone________________ ☐Work Phone________________

(PLEASE CHECK PREFERRED PHONE NUMBER OR E-MAIL AS PRIMARY CONTACT)

Ethnicity (√ one) ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Race (√ one) ☐African-American/Black ☐ Native American/Alaskan Native ☐ White ☐ Other________________
☐Asian/Pacific Islander ☐Asian-Indian ☐Cambodian ☐Chinese ☐Filipino ☐Guamanian ☐Hawaiian ☐Japanese
☐Korean ☐Laotian ☐Samoan ☐Vietnamese
☐ Decline to State

*The state law mandates reporting of certain medical diagnoses to the California Department of Health Services.

Employer________________________ Employer Address________________________________

Drivers License#________________ S.S.#________________ Occupation________________

Spouse's Name________________ Referred by________________ Primary Physician________________

Pharmacy________________ Address (Street, City)________________________ Phone________________

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

Name:________________________________ Subscriber's Name________________________________

Address______________________________ City________________ State________ Zip______

Home Phone________________ Work Phone________________ 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 #________________

EMERGENCY CONTACT

Name of person not living with you________________________________ Relation________________

Address______________________________ City________________ State________ Zip______

Home Phone________________ Work Phone________________ Cell Phone________________

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

SAN ANTONIO UROLOGY MEDICAL GROUP, INC.
Adult and Pediatric Urology

1175 East Arrow Highway, Suite E
Upland, California 91786-5525
Telephone: (909) 985-9737
Facsimile: (909) 981-1203

GENERAL CONSENT

I hereby consent and request to diagnostic procedures including x-rays, blood test, medical treatment, including immunizations treatment and deemed advisable by the professional staff of San Antonio Urology Medical Group, Inc.

I acknowledge that I have read this consent form and understand its contents. I have had an opportunity to discuss it, and any questions I had have been answered to my complete satisfaction.

____________________	____________________
WITNESS	**PATIENT'S SIGNATURE**
____________________	____________________
DATE	**PATIENT'S OR LEGAL GUARDIAN'S SIGNATURE**

CONSENTIMENTO GENERAL

Por este medio hago peticion y consiento en procedimientos diagnosticos incluyendo rayo-x, examenes de sangre y tratamiento medico, inclusive immizaciones las cuales se crean aconsejables por el personal.

Reconozo que he leido `este formulario de consentimento y entiendo su contenido. He tenido la oportuinidad de discutirlo y las preguntas que he hecho se han contestado a mi satisfaccion completa.

____________________	____________________
TESTIGO	**FIRMA DEL PACIENTE**
____________________	____________________
FECHA	**FIRMA DEL PADRE O TUTOR DEL PACIENTE**

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PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, whom we may inform about your general medical condition and your diagnosis:

____

____

II. Please list the family members or significant others, whom we may inform about your medical condition ONLY IN A EMERGENCY:

____

____

III. Please print the address of where you would like your billing statements and/ or correspondence from our office to be sent if other than your home.

____

____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES___ NO___

V. Please print the telephone number where you want to receive calls about your appointments, labs and x-ray results, or other health care information if other than your home phone number or cell phone (not a secure means of communication).

____

VI. Can confidential messages (ie. Appointment reminders) be left on your home answering machine or voice-mail (not necessarily a secure means of communication)?

YES___ NO___

VII. If you do not have voice-mail, can a confidential message be left at your place of employment?

YES___ NO___

VIII. I have been advised that I may have access to the HIPPA privacy rules and regulations regarding my healthcare. I would like to read the rules and regulations.

YES___ NO___

IX. I hereby authorize the release of all my medical history to all medical entities that may be pertinent to my care and insurance billing.

PATIENT NAME____________________________

________________________________ ____________
PATIENT/GUARDIAN IF UNDER 18 YEARS SIGNATURE DATE

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BILLING POLICY AND PROCEDURES

DEAR PATIENTS IN ORDER TO PREVENT MISUNDERSTANDINGS, WE WISH ALL OUR PATIENTS TO KNOW THE FOLLOWING:

1. For appointments that are not canceled, you will be charged up to one half the charge of that visit. The amount charged will not exceed you co-pay providing you have one. Cancellations need to be made 24 hours prior to your appointment.

2. We will provide courtesy billing for all our patients with accurate insurance billing information including billing address, claim form and copy of insurance card. If this information is not given at the time of service, it will be the patient's responsibility to pay for the services rendered.

3. Insurance companies do not always pay the entire bill. It is to be understood that any balance after payment by the insurance company will be shown on your statement and should be paid promptly, or an arrangement made.

4. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. The covered amount is set by the insurance carrier and may not be payment in full.

5. Your insurance is a contract between you, your employer and the insurance company.

6. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

7. It is your responsibility to check with your insurance company if prior authorization is required.

8. We **do accept** assignment of benefits from Medicare, which means the patient is responsible for 20% of the allowed of Medicare. As a courtesy to our Medicare patients secondary insurance is billed.

9. All co-payments and deductibles are payable at the time of service.

10. All accounts are due and payable within 60 days from the **date of service**, regardless of insurance coverage.

_______________	_______________
DATE	SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

San Antonio Urology Medical Group
1175 E. Arrow Highway, Suite E
Upland, CA 90786
(909) 985-9737

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I hereby authorize my Insurance Company to pay and hereby assign directly to San Antonio Urology Medical Group, Inc., all benefits, if any otherwise payable to me for their services as described on the attached form. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to San Antonio Urology Medical Group, Inc. will be credited to my account, in accordance with the said agreement.

____________________________ ____________________________

(Authorized Signature of Subscriber) (Date)

PLEASE NOTE

If you wish insurance to be billed, a claim form and card need to be presented when checking-in. Al co-pay are due at time of check in.

Please inform the office at least 24 hours prior to your appointment, if you are unable to keep it.

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Appointment policy

______We believe the doctor-patient relationship is an important and dynamic relationship that both parties participate in. Both parties have to take responsibility for care. It is our office policy that when a patient cancels an appointment, it is their responsibility to reschedule that appointment. We will not call you to reschedule a canceled appointment.

______If you do not keep a scheduled appointment we will send you a "no show letter" as a reminder. It is then your responsibility to call our office to reschedule your appointment.

______ Date

______________________________ Patient or responsible party signature

MEDICAL HEALTH HISTORY

REVIEWED BY ____________

DATE ____________

Name of Patient ____________________

Date ____________

ILLNESSES	Yes	No
Measles	__	__
Mumps	__	__
Polio	__	__
Meningitis	__	__
Tuberculosis	__	__
Cancer	__	__
Arthritis	__	__
Rheumatic Fever	__	__
Bleeding Tendency	__	__
Diabetes	__	__
Hypertension	__	__
Gout	__	__
Glaucoma	__	__
Hepatitis	__	__
AIDS exposure	__	__
Received blood products	__	__
Other ____________	__	__

OPERATIONS	Yes	No	Year
Tonsils	__	__	__
Appendix	__	__	__
Gallbladder	__	__	__
Stomach	__	__	__
Breast	__	__	__
Uterus	__	__	__
Ovary	__	__	__
Hernia	__	__	__
Testes	__	__	__
Prostate	__	__	__
Kidney	__	__	__
Thyroid	__	__	__
Heart	__	__	__
Hemorrhoids	__	__	__
Other ____________	__	__	__

ALLERGIES	Yes	No
Penicillin	__	__
Sulfa	__	__
IVP Dyes	__	__
Others ____________		

HABITS	Yes	No	
Tobacco	__	__	Packs/Day ____________
Alcohol	__	__	Type/Amount ____________
Drugs	__	__	Type/Amount ____________

INJURIES	Yes	No	Year
Head	__	__	__
Chest	__	__	__
Back	__	__	__
Genitalia	__	__	__
Kidneys	__	__	__
Abdomen	__	__	__
Other	__	__	__

MEDICINES	Reason	Dose
1. ____________	____________	____________
2. ____________	____________	____________
3. ____________	____________	____________
4. ____________	____________	____________
5. ____________	____________	____________
6. ____________	____________	____________
7. ____________	____________	____________
8. ____________	____________	____________

FAMILY HISTORY

Present age, or age at death
And cause of death:

Father ____________________

Mother ____________________

Brothers ____________________

____

____

Sisters ____________________

____

____

Have any blood relatives had:

	Yes	No	Relationship
Bleeding tendency	__	__	____________
Heart disease	__	__	____________
Tuberculosis	__	__	____________
High Blood Pressure	__	__	____________
Kidney disease	__	__	____________
Diabetes	__	__	____________
Cancer	__	__	____________
Kidney stones	__	__	____________
Gout	__	__	____________

REVIEW OF SYSTEMS

GENERAL	YES	NO
Fatigue	___	___
Marked weight change	___	___
Night sweats	___	___
Persistent fever	___	___
Sensitivity to heat/cold	___	___

HEENT	YES	NO
Decreased vision	___	___
Decreased hearing	___	___
Double vision	___	___
Glasses	___	___
Ringing in ears	___	___
Loss of smell	___	___
Nose bleed	___	___
Dental problems	___	___
Sore throat	___	___
Hoarseness	___	___

NECK	YES	NO
Stiffness	___	___
Swelling of neck	___	___

BREASTS	YES	NO
Lumps	___	___
Discharge	___	___

BACK	YES	NO
Pain	___	___
Arthritis	___	___

CNS	YES	NO
Headaches	___	___
Seizures	___	___
Fainting episodes	___	___
Nervousness	___	___
Dizziness	___	___
Epilepsy	___	___

GYN	
Last menstrual period	________
Last PAP smear	________
Age started menstruating	________
Interval between periods	________
Number of births	________
Number of pregnancies	________

LUNGS	YES	NO
Asthma	___	___
Tuberculosis	___	___
Pneumonia	___	___
Coughing up blood	___	___
Shortness of breath	___	___
Sputum	___	___

HEART	YES	NO
Heart attack	___	___
Irregular heart	___	___
Heart murmur	___	___
Chest pain	___	___
Swelling in ankles	___	___
Shortness of breath	___	___
Shortness of breath at night or lying down	___	___
How many pillows do you sleep on?	___	___

GI	YES	NO
Vomiting up blood	___	___
Black tarry stools	___	___
Hemorrhoids	___	___
Hepatitis	___	___
Peptic ulcer	___	___
Jaundice	___	___
Abdominal pain	___	___
Gallbladder disease	___	___
Diarrhea	___	___

GU	YES	NO
Pain on urination	___	___
Difficulty starting urine	___	___
How many times do you get up to void at night	___	
How many times per day do you void	___	
Loss of urine w/coughing	___	___
Vaginal or penile discharge	___	___
Incompletely empty bladder	___	___
Urinate more than before	___	___
Urinate less than before	___	___
Sex problems	___	___