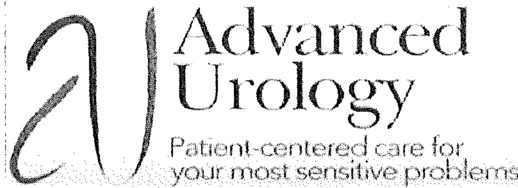

George Yamauchi, MD | Nickolas Tomasic, MD | Sameer Malhotra, MD | Faisal Ahmed, MD | Carrie Stewart, MD

Welcome to Advanced Urology!

Once you have an appointment with us, we will send you a New Patient packet via US Mail or Email. You can also download the forms via our website.

We utilize electronic medical records and will be able to set you up on your own PATIENT PORTAL when you arrive. Please come about 15 minutes prior to your appointment time to finish up any paperwork and register in our system.

To provide you the best attention and treatment, please bring the following with you on your first visit:

~ Your completed initial patient packet
~ Your driver's license, or other government issued photo I.D.
~ All medical Insurance cards
~ Pharmacy information, local or mail order
~ Any laboratory work including previous urinalysis, cultures, PSA blood tests.
~ Any relevant, imaging reports, and especially CD's such as ultrasounds, CT scans and MRI's
~ Current medication listing with correct spelling and dosage information

We look forward to meeting you and providing you with excellent Urology care.

Westchester
8540 S. Sepulveda Blvd Suite 911
Los Angeles, CA 90045

Redondo Beach
510 N. Prospect Suite 115
Redondo Beach, CA 90277

Culver City
9808 Venice Blvd Suite 602
Culver City, CA 90230

Website: WWW.AdvancedUrology.Net | Phone number: 310.670.9119

Patient Information

First ____________ MI _____ Last ________________________ DOB __________

Address ______________________________ Apt _____ City ______________

State ____________ Zip ____________

Social Security Number ______________ Sex: ☐ Male ☐ Female

>>>>>Please circle which number below we can leave a confidential medical message <<<<<

Main ______________ Cell ______________ E-Mail Address ______________

MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse name ______________

Employer ______________________________ Occupation ______________

Primary Doctor ______________________________ Phone # ______________

>>>>>>> Referred By ______________________________ Phone # ______________ <<<<<<<

Insurance Information (check one)

☐ PPO ☐ HMO ☐ SELF PAY ☐ MEDICARE/MEDICAL

PRIMARY INSURANCE ____________________ Policy Holder Name ____________________

☐ Self ☐ Spouse ☐ Parent Policy Holder Date of Birth ______________

Please confirm sign and date below

Sign Date

If other than Patient, please print name : ____________________ Relationship to Patient ____________

Westchester
8540 S. Sepulveda Blvd Suite 911
Los Angeles, CA 90045

Redondo Beach
510 N. Prospect Suite 115
Redondo Beach, CA 90277

Culver City
9808 Venice Blvd Suite 602
Culver City, CA 90230

Advanced Urology
Patient-centered care for your most sensitive problems

Patient Name: ______________________

Date of Birth: ______________________

Medical History

Reason for today's visit: ____

Current Medications: List all medications you are currently take including vitamins, herbal supplements, and over the counter medications.

Medication	Dosage	Medication	Dosage

Allergies:

____

Preferred Pharmacy:

Name	Address

Past Surgical History:

Type of Surgery	Year

Recent Hospitalizations:

Dates	Reason	Hospital

Personal Medical History (check all that apply to you)

☐ Anemia ☐ Asthma, Emphysema ☐ Bladder, Kidney infections ☐ Bleeding Disorder ☐ Blood Clots
☐ Blood in Urine/Stool ☐ Cancer ☐ Diabetes ☐ Erection Problems ☐ Gastrointestinal ☐ Heart Disease
☐ Hepatitis ☐ High Blood Pressure ☐ Incontinence ☐ Kidney Stones ☐ Pregnancies ☐ Prostate Cancer
☐ Stroke ☐ Urination problems

Other problems: ____

____

Vaccinations

Flu ☐ Yes ☐ No Pneumococcal ☐ Yes ☐ No

Vitals

Ht: __________ Wt: __________ BP: __________ Temp: __________ PVR: __________

Patient Name: ______________________

History of Tobacco Use:

___ Current Smoker ___ Former Smoker ___ Never Smoked

History of Alcohol Use:

___ Daily ___ Occasional ___ Former ___ Never

Family Medical History:

	Father	**Mother**	**Brother**	**Sister**
Alive	☐	☐	☐	☐
Cause of Death	________	________	________	________
COPD	☐	☐	☐	☐
CVA/TIA	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐
Myocardial Infarction	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐
Stones	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Other	________	________	________	________

ROS

	Yes	No		Yes	No		Yes	No
Constitutional	Yes	No	**Respiratory**	Yes	No	**ENTM**	Yes	No
Fever	☐	☐	Shortness of Breath	☐	☐	Hearing Loss	☐	☐
Cardiovascular	Yes	No	**Gastrointestinal**	Yes	No	**Musculoskeletal**	Yes	No
Chest Pain	☐	☐	Constipation	☐	☐	New Bone Pain	☐	☐
Hematologic	Yes	No	**Neurological**	Yes	No	**Immunologic**	Yes	No
Easy Bruising	☐	☐	Decreased Sensation	☐	☐	Latex Allergy	☐	☐
Genitourinary	Yes	No	**Pain**	Yes	No		Yes	No
Leak Urine/Wet Self	☐	☐	Are you experiencing pain?	☐	☐	Colonoscopy		

Are You Experiencing Any Other Symptoms Today? ______________________________________

____

____

AUMO Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices which provides information about how we may use and disclose Protected Health Information (PHI) about you. The notice details your rights under the law. You have the right to review our Notice before signing this Acknowledgment. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office or from our website.

Please check the first box below and sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of that Advanced Urology Medical Offices notice of Privacy Practices.

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from the patient, but it could not be obtained because: ______________________________

We cannot discuss your PHI with anyone other than yourself unless you authorize us to do so except for necessary instances allowing for disclosure as explained in our Notice of Privacy Practices. Please list below name(s) of the individual(s) (family, friends, etc.) with whom we may discuss your care. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

	Name	Relationship to Patient	Phone Number
1.	____________	____________	____________
2.	____________	____________	____________
3.	____________	____________	____________
4.	____________	____________	____________
5.	____________	____________	____________

______________________________ ______________________________

Name of Patient (print) Date of Birth

______________________________ ______________________________

Signature of Patient Date

______________________________ ______________________________

Signature of Patient Representative Date

(Required if patient is a minor or an adult who is unable to sign this form)

______________________________ ______________________________

Relationship of Patient Representative to Patient Print Name