Scott L. Brown, MD, FACS
Cameron W. Wilson, MD
Carrie M. Aisen, MD
Claudia Sevilla, MD

Dear Patient:

Thank you for choosing our practice for your urological care. We look forward to providing you with the best medical care.

The enclosed forms are being sent to you in advance to allow you time to carefully read and complete them.

1. The New Patient Information Record should be completed and signed. Please bring your insurance cards to your visit. We will ask to make a copy of them for your record.

   If your insurance requires a referral or an authorization, please make sure your primary physician has handled that requirement before your appointment. Without proper authorization, your appointment may have to be rescheduled.

2. The Health Questionnaire and Review of Systems provide the doctor with a complete medical history at your first visit. Please fill in all pages as completely as possible.

3. The Patient Waiver is an agreement that deals with patient responsibility regarding payment of charges for which your insurance does not pay.

Please bring these completed forms to your first visit along with your picture I.D. and insurance cards.

If you have questions regarding these forms, please call our office at (619) 828-1000.

8881 Fletcher Parkway • Suite 250 • La Mesa, CA 91942 • (619) 828-1000 • (619) 828-1001 Fax
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PATIENT INFORMATION FORM

PATIENT INFORMATION

Please complete this form in order to ensure proper billing of your services.

Patient Name: ______________________________

Date of Birth: ______ / ______ / ____________ Sex: ☐ Male ☐ Female ☐ Other SSN: XXX-XX- ____________

Patient Address: ____________________ City: ______________ State: ______ Zip: ______

(Please check the box to indicate your preferred means of communication)

☐ Cell Phone: ____________________

☐ Home Phone: ____________________ ☐ Email: ____________________

Employer: ____________________ Marital Status: ____________________

Race: ☐ American Indian/Alaska Native ☐ Black/African American ☐ White/Caucasian ☐ Asian
☐ Hawaiian/Pacific Islander ☐ Other ☐ Declined ☐ Unknown

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined ☐ Unknown

Language: ____________________ ☐ Interpreter Needed: ____________________

Spouse's Name: ____________________ Spouse's Date of Birth: ____________________

Emergency Contact: ____________________ Relationship to Patient: ____________________

Home Phone: ____________________ Other Phone: ____________________

Primary Care Physician: ____________________ Referring Physician: ____________________

IF THE PATIENT IS A MINOR OR STUDENT

Parent Name: ____________________ Home Phone: ____________________

Parent Address: ____________________ City: ______________ State: ______ Zip: ______

Email: ____________________ Parent's Employer: ____________________

Occupation: ______________ How Long Employed? ____________ Business Number: ____________

Employer's Address: ____________________ City: ______________ State: ______ Zip: ______

INSURANCE INFORMATION

Primary Insurance Information Plan Name: ____________________

Policy Holder: ____________________ Effective Date: ____________________

Insurance ID#: ____________________ Group #: ____________ Plan #: ____________

Secondary Insurance Information Plan Name: ____________________

Policy Holder: ____________________ Effective Date: ____________________

Insurance ID #: ____________________ Group #: ____________ Plan #: ____________

Other Insurance Information Plan Name: ____________________

Policy Holder: ____________________ Effective Date: ____________________

Insurance ID #: ____________________ Group #: ____________ Plan #: ____________

PHARMACY AND LABORATORY INFORMATION

Pharmacy Name: ______________________________

Pharmacy Phone Number: ______________________________

Address: ______________________________

Pharmacy Benefit Provider: ______________________________

Plan Number: ______________________________

Contracted Laboratory: ______________________________

Laboratory Phone Number: ______________________________

AUTHORIZATION

Do we have permission to talk to another person (Spouse, Family Member) About Your Medical Condition Or Account Information? ☐ Yes ☐ No

Besides yourself, who is authorized to discuss your medical health?

Name: ______________________ Phone Number: ______________ Relation to You: ______________
(Please Print)

Name: ______________________ Phone Number: ______________ Relation to You: ______________
(Please Print)

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to our practice.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.**

Signed: ______________________________ Date: ______________________________

HEALTH QUESTIONNAIRE

☐ Scott L. Brown, MD, FACS ☐ Carrie M. Aisen, MD
☐ Cameron W. Wilson, MD ☐ Claudia Sevilla, MD

Date: ____________________

Name: ______________________________ (last) (first) (middle) Age: __________ Height: __________ Weight: __________

Main Complaint: ______________________________ Referring Doctor: ______________________________

HISTORY OF MAIN COMPLAINT

(check "yes" or "no" where applicable):

	YES	NO
1. Do you have:		
a) blood in your urine?	☐	☐
b) burning when urinating?	☐	☐
c) discharge?	☐	☐
2. How often do you urinate?		
a) at night (_______ times)		
b) during the day (_______ times)		
3. Do you need to get to the toilet quickly when you need to urinate?	☐	☐
4. Do you leak urine/wet your underwear		
a) with sneezing?	☐	☐
b) with coughing?	☐	☐
c) with laughing?	☐	☐
d) with walking?	☐	☐
e) anytime?	☐	☐

	YES	NO
5. When you urinate (pass urine):		
a) do you have to wait awhile before you start to void?	☐	☐
b) is your stream weaker than it used to be or than you consider normal?	☐	☐
c) do you dribble at the end of urination?	☐	☐
d) do you still feel full or not completely empty when you are finished voiding?	☐	☐
e) do you need to urinate a second time after urinating?	☐	☐

UROLOGICAL HISTORY

(check "yes" or "no" where applicable):

	YES	NO
6. Have you had:		
a) previous urological treatments or tests (e.g. cystoscopy)?	☐	☐
b) kidney stones?	☐	☐
c) urinary tract infections?	☐	☐
d) kidney or bladder injuries?	☐	☐
e) sexually transmitted infections?	☐	☐
7. With any of the foregoing, have you experienced?		
a) fever?	☐	☐
b) chill?	☐	☐
c) back pain (how long: _______)?	☐	☐
d) weight loss (# of lbs: _______)?	☐	☐

	YES	NO
8. **MEN ONLY:**		
a) Are you able to get an erection?	☐	☐
b) Any family history of prostate cancer?	☐	☐
c) Do you sit to void (urinate)?	☐	☐

COMMENTS: ______________________________

____

____

9. **WOMEN ONLY:**
Do you experience any of the following?
☐ Painful Intercourse
☐ Vaginal Burning/Itching
☐ Urinary Incontinence
☐ Vaginal Dryness
☐ Chronic Vaginal Infections
☐ Chronic UTI's

SURGERIES AND SERIOUS ILLNESSES

List all surgeries and serious medical illnesses you have had:

Type of Surgery & Reason for Surgery	Year	Name of Serious Illness & Duration:	Year

PLEASE COMPLETE REVERSE SIDE

ALLERGIES

10. Have you had any problems with an x-ray study in the past? ☐ YES ☐ NO
    If yes, when? ______________ What kind of reaction? ______________
11. Are you allergic to IVP dye or iodine? ☐ YES ☐ NO
12. Do you have asthma? ☐ YES ☐ NO Eczema? ☐ YES ☐ NO Hay fever? ☐ YES ☐ NO

LIST ALL KNOWN ALLERGIES:	TYPE OF REACTION

MEDICATIONS

List all medications you are currently taking:

Name of Drug	Strength	Amount	Frequency	Length of Time Taken

13. Do you take aspirin or similar agents? ☐ YES ☐ NO
14. Do you wear dentures? ☐ YES ☐ NO
15. Have you ever had a blood transfusion? ☐ YES ☐ NO

FAMILY HISTORY

Name	Age	Living	Illnesses	Deceased	Cause of Death
Father					
Mother					
Spouse (if married)					
Siblings/Children (list)					

PERSONAL HISTORY

Occupation: ______________ Birth Date: ______________ Martial Status: M S W DIV SEP

Do you or did you smoke? ______________ How long? ______________ How many per day?______________

Do you or did you drink? ______________ How long? ______________ How often?______________

Do you now or have you ever used drugs (e.g. marijuana, cocaine)? ______________

What type and how often?______________

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REVIEW OF SYSTEMS

REVIEW OF SYSTEMS

Please check all the apply:

System	Symptom	Y	N
GENERAL	Weight change	☐	☐
	Weakness	☐	☐
	Fatigue	☐	☐
	Fever	☐	☐
SKIN	Rashes	☐	☐
	Sores	☐	☐
	Itching	☐	☐
	Color changes	☐	☐
HEAD	Headache	☐	☐
	Head injury	☐	☐
EYES	Eye pain	☐	☐
	Double vision	☐	☐
	Glaucoma	☐	☐
	Cataracts	☐	☐
EARS	Tinnitus	☐	☐
	Vertigo	☐	☐
	Infection	☐	☐
NOSE & SINUSES	Nasal stuffiness	☐	☐
	Nosebleeds	☐	☐
	Sinus trouble	☐	☐
MOUTH & THROAT	Bleeding gums	☐	☐
	Hoarseness	☐	☐
NECK	Neck pain	☐	☐
	Goiter (lump in throat)	☐	☐
	Enlarged thyroid	☐	☐
BREASTS	Lumps	☐	☐
	Breast pain	☐	☐
	Nipple discharge	☐	☐
RESPIRATORY	Cough	☐	☐
	Sputum	☐	☐
	Cough up blood	☐	☐
	Wheezing	☐	☐
	Asthma	☐	☐
	Pneumonia	☐	☐
	Tuberculosis	☐	☐

System	Symptom	Y	N
CARDIAC	Heart attack	☐	☐
	High blood pressure	☐	☐
	Rheumatic fever	☐	☐
	Murmurs	☐	☐
	Chest pain/angina	☐	☐
	Palpitations	☐	☐
	Shortness of breath with walking	☐	☐
GASTROINTESTINAL	Trouble swallowing	☐	☐
	Nausea or vomiting	☐	☐
	Constipation	☐	☐
	Diarrhea	☐	☐
	Bloody stools	☐	☐
	Abdominal pain	☐	☐
	Jaundice	☐	☐
	Hepatitis A ☐ B ☐ C ☐	☐	☐
PERIPHERAL VASCULAR	Leg cramps	☐	☐
	Varicose veins	☐	☐
	Blood clots in legs	☐	☐
MUSCULOSKELETAL	Joint pain	☐	☐
	Arthritis	☐	☐
	Back pain	☐	☐
NEUROLOGIC	Fainting	☐	☐
	Seizures	☐	☐
	Paralysis	☐	☐
	Numbness	☐	☐
	CVA (stroke)	☐	☐
HEMATOLOGIC	Easy bruising	☐	☐
	Bleeding disorder	☐	☐
	Blood transfusion	☐	☐
	Blood thinning medication (e.g. Coumadin)	☐	☐
	Anemia (low blood count)	☐	☐
ENDOCRINE	Thyroid trouble	☐	☐
	Diabetes	☐	☐
PSYCHIATRIC	Nervousness	☐	☐
	Depression	☐	☐

Patient Name: ______________________ Patient Signature: ______________________

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NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At our practice, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 16, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit our practice, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of our practice, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Our practice, is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observation. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology department, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your case or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent, authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member of business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

PATIENT WAIVER FORM

☐ Scott L. Brown, MD, FACS
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PATIENT WAIVER FORM

The Doctor accepts you as his/her patient with the understanding that you are ultimately responsible for the cost of all professional services rendered by him to you and/or your dependents.

DEPENDING UPON YOUR INSURANCE CONTRACT BENEFITS, YOU MAY BE RESPONSIBLE FOR PORTIONS OF THE CHARGES NOT COVERED BY YOUR INSURANCE.

WE WILL MAKE EVERY EFFORT TO WORK WITH YOUR INSURANCE COMPANY BUT IN THE EVENT A BALANCE IS DUE PLEASE CONTACT US TO MAKE ARRANGEMENTS TO SETTLE YOUR ACCOUNT.

I have read and understand the above policy.

____

Patient Name (Please Print)

____

Patient Signature

____

Date

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