PATIENT INFORMATION
Please complete ALL Areas

Date:__________ MRN:________________________ SSN:________________________

Last Name:____________________________First Name:__________________ MI____

DOB:_________________ Age:________ Gender: M F Race:__________________

Ethnicity______________ Marital Status______________Preferred Language_______

Address:________________________________City____________________ State____

Zip Code:__________________

Home Phone:____________________ Cell Phone________________________

Work Phone:_____________________ email:__________________________________

Employer:____________________________ Occupation:________________________

Address:_____________________________ City:_______________________State___

Zip Code:__________________

Primary Doctor:___________________________ Phone:_______________________

Referred By:______________________________

If Minor, name of responsible party:

Name:_______________________Relationship_______________ Phone:__________

In Case of an Emergency, contact:

Name:_______________________Relationship:_____________Phone:___________

Insurance Coverage:_________________ Guarantor__________________________

Medicare #___________________________ Medical #__________________________

Pharmacy Name:____

Pharmacy Address:____

Pharmacy Phone:____

Date **Signature**

GOLDEN GATE UROLOGY, INC.
HERNANDEZ & GRADY

Patient Information and Medical History

Last Name ______________________________ First Name ____________________________ Gender: M F

Date of Birth ______________________ Current Age _____________ Date ______________________________

Drug Allergies ____
Other Allergies ____

MEDICAL HISTORY

________Diabetes
________ Lung Disease
________COPD
________Asthma
________Cancer

____Coronary disease
____High Blood pressure
____Myocardial infarction (heart attack)
____Bleeding disorder
____Glaucoma
____Arthritis

____Gout
____Kidney stones
____Thyroid disease
____Cancer type ________________________________
____
___Peripheral vascular disease (stroke, aneurysm, poor Blood flow)
____Kidney disease
___ _Other ______________________________________
____

PREVIOUS SURGICAL PROCEDURES

(Please list the approximate year of the surgery)

____
____
____
____
____
____

MEDICATIONS AND DOSE (MG)

____
____
____
____
____
____
____
____

PERSONAL HISTORY

____Smoker
____Recreational drug use
Marital Status (Please circle)
Single Married Divorced Widow/Widower
Do you drink alcohol? Y N If yes, please list what you drink and your amount of consumption
____
____
Do you drink coffee/tea? Y N If yes, please list Amount of consumption ______________________
____

PAST FAMILY HISTORY: IF A BROTHER, SISTER, FATHER, OR MOTHER HAS HAD ANY OF THE FOLLOWING DISEASES, PLEASE NOTE, AND STATE RELATIONSHIP

____Diabetes ________________________________
_____Hypertension ___________________________
_____Lung Disease ___________________________
(COPD, Asthma, Cancer)
_____Coronary Disease _______________________
_____Myocardial Infarction __________________
(Heart Attack) ______________________________
_____Arthritis ______________________________

_____Kidney stones ___________________________
_____Kidney disease __________________________
_____Thyroid disease _________________________
_____Cancer _________________________________
_____Other __________________________________

Patient Name:____________________________________Date:________________

Constitutional Systems				Genitourinary		
Appetite change	Y	N		Blood in urine	Y	N
Chills	Y	N		Frequent urination	Y	N
Fever	Y	N		Painful urination	Y	N
Headache	Y	N		Urgency	Y	N
Weight loss	Y	N		Bladder not emptying	Y	N
Eyes				Straining to void	Y	N
Blurred vision	Y	N		Leaking	Y	N
Eye Pain	Y	N		with coughing	Y	N
Ears, Nose, Throat				with urgency	Y	N
Sinus congestion	Y	N		Pain with intercourse	Y	N
Sore throat	Y	N		Testicle pain (Male)	Y	N
Ringing in ear(s)	Y	N		Poor erections (Male)	Y	N
Hearing loss	Y	N		No erections (Male)	Y	N
Respiratory				Testicle mass/lump (Male)	Y	N
Chronic cough	Y	N		Heavy Periods (Female)	Y	N
Shortness of breath	Y	N		Painful periods (Female)	Y	N
Coughing up blood	Y	N		Vaginal discharge (Female)	Y	N
Cardiovascular				**Musculoskeletal**		
Angina	Y	N		Arthritis	Y	N
Palpitations	Y	N		Back pain	Y	N
Chest pain	Y	N		Joint pain	Y	N
Ankle Edema	Y	N		**Endocrine**		
Gastrointestinal				Excessive sweating	Y	N
Abdominal pain	Y	N		Excessive thirst	Y	N
Constipation	Y	N		Excessive weight gain	Y	N
Diarrhea	Y	N		Excessive weight loss	Y	N
Heartburn	Y	N		**Hematological**		
Nausea/vomiting	Y	N		Bleeding problem	Y	N
Black stools	Y	N		Swollen glands	Y	N
Skin				Easy bruising	Y	N
Persistent itching	Y	N		**Neurological**		
Unusual lesions	Y	N		Dizzyness	Y	N
Rash	Y	N		Numbness	Y	N
Jaundice	Y	N		**Psychiatric**		
Physician Signature				Insomnia	Y	N
				Anxiety	Y	N
Date:				Depression	Y	N
				Suicidal thoughts	Y	N

CANCELLATION AND MISSED APPOINTMENT POLICY

Dear patient:

We try earnestly to offer friendly and timely service that accommodates your needs. Our goal is always to offer the earliest and most convenient appointment for you To achieve this goal, we need to live with some rules. Many of you wait anxiously for you turn and we want to make that wait as short as possible. Please understand this policy benefits everyone. Help us be available for you.

OFFICE APPOINTMENTS

No fee will be assessed when an appointment is cancelled or re-scheduled **48 hours or more** in advance.

When an appointment is "missed" (no show) without any notification or **when an appointment is cancelled with less than 48 hours notification, the following fees will apply**

- ➡ **$200.00** for appointments made for any office procedures and office surgeries
- ➡ **$50.00** for any other appointments

HOSPITAL OR OUTPATIENT SURGERIES

No fee will be assessed for surgeries cancelled or re-scheduled with **more than 3 days in advance.**

For surgeries cancelled or re-scheduled less than 3 days in advance will be subject to a $300.00 fee.

GENERAL CONSIDERATION

If an appointment is rescheduled with less than 48 hours notice or missed more than 3 times in a period of 6 months, the office will offer the contact information of other practitioners that might better suit your schedule.

I HAVE READ AND UNDERSTAND THESE POLICIES AS WRITTEN ABOVE

____

Signature

____

Print Name **Date**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper , or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose you health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also crate and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

NOTICE OF PRIVACY PRACTICES

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right of to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

ACKNOWLEDGEMENT OF NOTICE FORM HERNANDEZ AND GRADY, A MEDICAL CORPORATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I, ____, have read a copy of
Patient Name, Please Print

HERNANDEZ AND GRADY'S NOTICE of Privacy Practices.

____ ____________________
Signature of Patient Date