

EL CAMINO UROLOGY MEDICAL GROUP, INC.

PATIENT NAME: _____ DATE: _____

(FIRST) (M.I.) (LAST)

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED CHILD

BIRTHDATE: _____ AGE: _____ MALE FEMALE

STREET ADDRESS: _____ HOME PHONE: (____) _____

CITY, STATE: _____ ZIP: _____ CELL PHONE: (____) _____

PATIENT'S SOC. SEC. #: _____ BUS. PHONE: (____) _____

EMPLOYED BY: _____ OCCUPATION: _____

NAME OF SPOUSE OR PARENT: _____ OCCUPATION: _____

EMPLOYED BY: _____ SPOUSE'S S. S. #: _____

SPOUSE'S BIRTHDATE: _____ BUS. PHONE: (____) _____

FAMILY PHYSICIAN: _____ TELEPHONE: _____

REFERRED BY: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE):

NAME	RELATIONSHIP	PHONE #
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- WE BILL ALL INSURANCES IF PROVIDED WITH PROPER INFORMATION.
- PLEASE PRESENT ALL INSURANCE CARDS FOR PHOTOCOPYING.

MANAGED CARE PATIENTS:

IT IS YOUR RESPONSIBILITY TO KEEP THIS OFFICE INFORMED REGARDING REFERRALS, AUTHORIZATIONS, AND ANY SPECIAL X-RAY OR LAB REQUIREMENTS.

<p>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim or for preauthorization requirements.</p> <p>Signed: _____ Date: _____</p>	<p>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to my physician for services rendered.</p> <p>Signed: _____ Date: _____</p>
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Patient Name _____

Over the past month, typically how often have you experienced:	Not at All	Less than 1 time in 5.	Less than half of the time.	About half of the time.	More than half of the time	Almost Always	
INCOMPLETE EMPTYING A sensation of not emptying your bladder completely after you finished urinating.	0	1	2	3	4	5	
FREQUENCY Urinating again less than 2 hours after you finished urinating.	0	1	2 ✓	3	4	5	
INTERMITTENCY Stopping and starting again several times when you urinate.	0	1	2	3	4	5	
URGE TO URINATE Finding it difficult to postpone urination.	0	1	2	3	4	5	
WEAK STREAM Minimal urinary stream.	0	1	2	3	4	5	
STRAINING Needing to push or strain to begin urination.	0	1	2	3	4	5	
URINATING AT NIGHT Number of times you typically get up to urinate from the time you went to bed at night until the time you got up in the morning.	0	1	2	3	4	5	
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	Delighted 0	Pleased 1	Mostly Satisfied 2	Mixed 3	Mostly dissatisfied 4	Unhappy 5	Terrible 6

Gynecologic / Obstetric History

Menstrual history: Age at First Menses _____ Currently menstruating: YES / NO
 If yes, are periods regular: YES / NO
 Spacing of periods _____ Duration of Bleeding _____
 If no, when did periods stop _____ Menopause or Hysterectomy?
 Date of last PAP smear _____ Any abnormal PAP smears YES / NO
 If yes, specify: _____

Obstetric history:

Total pregnancies _____ Vaginal deliveries _____ C-sections _____ Abortions _____ Miscarriage _____
 Complicated deliveries YES / NO
 If yes, specify: _____

What is your main concern that you would like the doctor to address?

EL CAMINO UROLOGY MEDICAL GROUP, INC.

2480 Hospital Drive, Suite 210
Mountain View, CA 94040-4397

Dear Patient:

Medicare will not pay for supplies such as:

Leg bags	\$11-15
Catheters	\$16
Incontinence Clamps	\$45
Urinal	\$10
Lubricant	\$13
Syringes	Varies
Medicated Wipes	\$15/box
Other Supplies	Varies

I understand I am responsible for payment of these supplies.

Signed _____ Date _____