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 #

- 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.

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.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to my physician for services rendered.
Signed: ______________ Date: ________	Signed: ______________ Date: ________

EL CAMINO UROLOGY MEDICAL GROUP
2490 Hospital Drive, Suite 210, Mountain View, CA 94040
Phone (650) 962-4662 Fax (650) 962-4652

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

Do you have a decrease in libido (sex drive)? YES / NO

Do you have lack of energy? YES / NO

Do you have a decrease in strength and/or endurance? YES / NO

Have you lost height? YES / NO

Have you noticed a decreased "enjoyment of life"? YES / NO

Are you sad and / or grumpy? YES / NO

Are your erections less strong? YES / NO

Have you noticed a recent deterioration in your ability to play sports? YES / NO

Are you falling asleep after dinner? YES / NO

Has there been a recent deterioration in your work performance? YES / NO

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*________________