Child's History Form

Patient Name: _____ Date of Birth: _____ Age:____

Chief Complaint (What is the main reason for you visit with the urologist today)?

_____

History of Present Illness

Please bubble in the appropriate response

Blood in Urine……O Yes O No

Weak, dribbling stream or trouble starting a stream (poor force)……..O Yes O No

Urinating more frequently than usual? If yes, how often? _____ ……...O Yes O No

Awakening frequently at night to urinate? If yes, how often? _____ …….O Yes O No

Wetting the bed at night……...O Yes O No

Daytime wetting of clothes……..O Yes O No

Burning or pain with urination……O Yes O No

Back pains……O Yes O No

Abdominal Pains……...O Yes O No

Constipation or trouble with daily bowel movement…….....O Yes O No

Urinary Tract Infection……O Yes O No

Skin problems in the genital or groin area……O Yes O No

Ever had kidney x-rays or ultrasounds performed……..O Yes O No

Is your child presently under the care of a doctor for any chronic medical or surgical problems? _____

If yes, please describe: _____

What was your child's weight at birth? _____

To date, has your child attained age-appropriate developmental milestones such as crawling, walking, talking, feeding and dress? _____ Yes _____ No

Is your child in school or daycare? _____ Yes _____ No

Is your child exposed to cigarette smoke? _____ Yes _____ No

Family History - Please write "F" for father, "M" for mother, and "S" for sibling

_____ Prostate Cancer _____ Kidney Cancer _____ Bladder Cancer

_____ Kidney Failure _____ Kidney Stones _____ Heart Disease

_____ Lung Disease _____ High Blood Pressure _____ Neurological problems

_____ Other illnesses? _____

Patient Name: _____ Date of Birth: _____ Age:____

Medications

Please list all prescriptions and over-the-counter medications, vitamins, and herbs your child is taking.

Does your child have any **ALLERGIES TO MEDICATIONS**? _____ Yes _____ No

If yes, what medication(s)? _____

Has your child ever had a reaction to **X-RAY DYE**? _____ Yes _____ No

If yes, what type of reaction? _____

Is your child allergic to **LATEX**? _____ Yes _____ No

Is your child currently on any **BLOOD THINNERS**? _____ Yes _____ No

If yes, what medication(s)? _____

Past Medical History

Please list all past medical history (i.e. high blood pressure, diabetes, heart attack, asthma, etc.):

_____

_____

_____

Surgical History

Please list all past surgeries and include dates, if known:

_____

_____

_____

Has your child ever been hospitalized? _____ Yes _____ No

If yes, for what condition and if known, what date(s)? _____

Has your child had any recent labs or x-rays done? _____ Yes _____ No

If yes, what was done and where? _____

Patient Name: _____ Date of Birth: _____ Age: _____

Review of Systems

GENERAL

Weight loss	O Yes O No	Change in appetite	O Yes O No	Night sweats	O Yes O No
Fatigue	O Yes O No	Nausea	O Yes O No	Fever	O Yes O No
Chills	O Yes O No				

HEAD/EYES/EARS/NOSE/THROAT

Headache	O Yes O No	Decreased hearing	O Yes O No	Ringing in the ears	O Yes O No
Congestion	O Yes O No	Eye Pain	O Yes O No	Dental Problems	O Yes O No
Dry mouth	O Yes O No	Difficulty swallowing	O Yes O No	Eye problems	O Yes O No
Sore throat	O Yes O No				

RESPIRATORY

Cough	O Yes O No	Sputum production	O Yes O No	Bloody Phlegm	O Yes O No
Shortness of breath	O Yes O No				

CARDIOVASCULAR

Chest pain	O Yes O No	Irregular heartbeat	O Yes O No	Leg Cramps	O Yes O No
Easy Bruising	O Yes O No	High blood pressure	O Yes O No	Low blood pressure	O Yes O No

GASTROINTESTINAL

Painful swallowing	O Yes O No	Stomach problems	O Yes O No	Vomiting	O Yes O No
Blood in stool	O Yes O No	Rectal bleeding	O Yes O No	Constipation	O Yes O No
Diarrhea	O Yes O No				

NEUROLOGICAL

Paralysis	O Yes O No	Tremor	O Yes O No	Developmental Problems	O Yes O No
Balance difficulty	O Yes O No	Memory loss	O Yes O No		

MUSCULOSKELETAL

Weakness	O Yes O No	Difficulty Walking	O Yes O No	Painful joints	O Yes O No
Loss of Muscle Mass	O Yes O No				

ENDOCRINE

Excessive thirst	O Yes O No	Cold intolerance	O Yes O No	Poor growth	O Yes O No

SKIN

Change in skin or nail texture	O Yes O No	Itching	O Yes O No
Hives	O Yes O No	Dry skin	O Yes O No

SEQUOIA UROLOGY CENTER

Chris Threatt, M.D. ~ Marina White-Nagy, M.D.

PATIENT REGISTRATION FORM

Please print and complete ALL sections below

Today's date:	Primary Care Physician:	Referring Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (select one) ☐Single ☐Mar ☐Div ☐Sep ☐Wid

Street address:	City:	State:	Zip Code:

Social Security no.: (required if billing insurance)	Home phone:	Cell phone no.:

Birth date:	Age:	Sex: ☐ M ☐ F	Pharmacy Name:	Street/City of your pharmacy:

Okay to download medication history? ☐ Yes ☐ No	Email Address:

Occupation:	Employer:	Employer phone no.:

Do you have an Advance Directive : ☐ Yes ☐ No if Yes DNR ☐ Yes ☐ No Surrogate Decision Maker : ☐ Yes Name:

Do you have power of attorney? ☐ Yes ☐ No If yes, person's name: Phone Number:

Ethnicity:	Race:	Preferred Language:

Spouse's Name(If applicable):	Spouse's date of birth:

Referred to Sequoia Urology Center by? (please check one box)	☐ Dr. _____ Name	☐ Insurance Company ☐ Hospital ☐ Yellow Pages	☐ Family ☐ Friend ☐ Website/Internet Search

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Cell phone no.:

INSURANCE INFORMATION (Please give your insurance card to the receptionist.)

Name of PRIMARY insurance:	ID/policy no.:	Group no.:

Policy Holder's Name:	Birth date:	Policy Holder's S.S. no.:	Employer:

Patient's relationship to policy holder: ☐ Self ☐Spouse ☐Child ☐Other

Name of SECONDARY insurance (if applicable):	ID/Policy no.:	Group no.:

Policy Holder's Name:	Birth date:	Policy Holder's S.S. no.:	Employer:

Patient's relationship to policy holder: ☐Self ☐Spouse ☐Child ☐Other

FINANCIAL POLICY

CASH PATIENTS

- Full payment at time of service.
- We accept CASH, CHECK, and VISA, MASTERCARD, and AMERICAN EXPRESS

HMO / PPO HEALTH PLANS

- "REFERRALS" from your primary care physician and CO-PAYMENTS and / or your percentage are due at the time of your visit or service.

PRIVATE INSURANCE CARRIERS

- When we are provided with insurance information, we will submit the visit to your insurance company for you.
- On subsequent visits, we will bill your insurance carrier; although we expect any deductibles and co-payment percentages at the time of your visit**. If your co-payment is not made at the time of your visit a $5 processing fee will be added to your next statement.** If your insurance has not paid the full balance within 45 days, then you are responsible and we expect payment from you within 15 days upon the receipt of our statement.

  Insurance coverage is a contract between you and your insurance company. We are not a party to this contract in most cases. Your insurance claim is filed as a courtesy to our patients. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, etc., other than to supply factual information as necessary**. You are ultimately responsible for all charges regardless of any existing medical coverage.**

MEDICARE, MEDI-CAL, WORKERS COMPENSATION

- If you are covered by Medicare, Medi-Cal, Workers Compensation or any other government-sponsored program, we require that you have proof of such coverage for billing purposes.

Should your account become past due, you will be responsible for any finance charge or legal fees necessary to collect on this account.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

CANCELLED APPOINTMENTS

- ***This office requires a 24-hour notice if you are unable to keep your scheduled appointment, 48-hour notice for any procedures or surgeries.***
- ***A $50 cancellation fee has been implemented in order to reduce the amount of failed OV appointments or appointments cancelled by patients without proper notice. The cancellation fee for procedures or surgeries will be 50% of the procedure charge up to a maximum of $500.00.***

Responsible Party Signature: _____

Print Name: _____ *Dated:* _____

CHRIS THREATT, M.D.
MARINA WHITE-NAGY, M.D.
PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I have received the Sequoia Urology Center, Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any further Notice of Privacy Practices if amended. I wish to be contacted in the following manner (check all that apply):

□ **Home Telephone _____**
- □ **O.K. to leave message with detailed information**
- □ **Leave message with call-back number only**

□ **Cell Phone _____**
- □ **O.K. to leave message with detailed information**
- □ **Leave message with call-back number only**

□ **Written Communication**
□ **O.K. to mail to my home address**
□ **O.K. to mail to my work/office address**
□ **O.K. to fax to this number_____**
□ **Family members authorized to receive medical information _____**

_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

- ***AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES***
  I herby authorize Sequoia Urology Center to release any information in the course of my examination and/or treatment to my insurance company(s) for the purpose of billing. I also authorize the release of information to my employer if my examination and/or treatment are work related.

- ***AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN***
  I herby authorize the medical and/or surgical benefit payments to be made directly to Sequoia Urology Center. It is understood that benefits are not to exceed the reasonable and customary charge of these services and any monies received from the insurance company over and above indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges not covered by this authorization.

- ***INFORMED CONSENT FOR OFFICE PROCEDURES***
  I herby authorize the staff and physicians of Sequoia Urology Center to perform those diagnostic and/or therapeutic office procedures deemed necessary to evaluate and/or treat my current medical illness(es). I make this authorization with the knowledge that the above names company will verbally describe the nature of said procedures in lay terminology, including possible complications, alternatives, and side effects and obtain verbal consent prior to procedures. I retain the right to verbally refuse any procedure, either diagnostic or therapeutic, after being informed of its nature, complications, and side effects.

- ***PATIENT ACKNOWLEDGMENT OF PHYSICIAN DISCLOSURE OF OWNERSHIP % INTEREST***
  This is to advise you that the doctors have ownership interest in certain diagnostic equipment and diagnostic treatment centers to which you may be referred. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than the one which you have been referred.

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS.

_____ _____

Print Patient Name **Patient's Birthdate**

_____ _____

Patient Signature or authorized representative/ relationship (if applicable) **Date**