

# Sequoia Urology Center

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Adult and Pediatric Urology \* Male Infertility \* Impotence \* Incontinence

Dear \_\_\_\_\_:

Welcome to Sequoia Urology Center. We are pleased that you have chosen us to provide you with your medical services.

Please request your primary care or referring physician to fax to our office any pertinent medical information prior to your appointment.

Enclosed are the new patient registration forms and information. Please complete and bring with you to your appointment unless you have completed on the patient portal:

- Patient information sheet;
- Health history form;
- Consent / authorization form
- Financial policy
- **If you are unable to bring the completed forms with you, please plan on arriving 30 minutes early to finish the forms prior to your appointment time.**

Upon arrival for your appointment, we ask that you check-in with our receptionist. In addition to the completed forms you will be giving her if not done on-line, she will need:

- A copy of your insurance card(s);
- Photo Identification – (Due to new HIPAA/Identity Theft rules if the address is incorrect on your ID we will need a copy of a utility bill showing proof of your correct address)
- “Referral” or “authorization” form from your health plan (if required)
- Co-payments your health plan requires
- To take your picture for our electronic medical records

It is our desire to make your visit a pleasant one. If you have any questions, please ask – we want to be of assistance and look forward to meeting you.

Your appointment is scheduled at Sequoia Urology Center on \_\_\_\_\_ at \_\_\_\_\_ am / pm; in the following office location:

- 2900 Whipple Ave, Ste. 130  
Redwood City, CA 94062  
Ph:(650) 362-8250



## **DIRECTIONS TO THE OFFICE**

**2900 WHIPPLE AVE, STE 130  
REDWOOD CITY, CA 94062**

### **HEADING SOUTHBOUND ON 101**

TAKE THE WHIPPLE AVE EXIT TURN RIGHT ON TO WHIPPLE AT THE STOP LIGHT.

CONTINUE ON WHIPPLE AVE PAST 4 STOP LIGHTS AND CONTINUE PAST SEQUOIA HOSPITAL. AFTER THE HOSPITAL EMERGENCY ROOM ENTRANCE YOU WILL TURN RIGHT AT THE NEXT DRIVEWAY. CONTINUE ALL THE WAY TO THE BUILDING AT THE TOP OF THE HILL WHICH IS 2900 WHIPPLE AVE. WE ARE LOCATED ON THE FIRST FLOOR.

### **HEADING NORTHBOUND 101**

TAKE THE WHIPPLE AVE EXIT TURN LEFT ONTO WHIPPLE AT THE STOP LIGHT.

CONTINUE ON WHIPPLE AVE PAST 5 STOP LIGHTS AND CONTINUE PAST SEQUOIA HOSPITAL. AFTER THE HOSPITAL EMERGENCY ROOM ENTRANCE YOU WILL TURN RIGHT AT THE NEXT DRIVEWAY. CONTINUE ALL THE WAY TO THE BUILDING AT THE TOP OF THE HILL WHICH IS 2900 WHIPPLE. WE ARE LOCATED ON THE FIRST FLOOR.

### **FROM 280 IN EITHER DIRECTION**

TAKE THE EDGEWOOD RD EXIT EASTBOUND.

CONTINUE ON EDGEWOOD UNTIL THE LIGHT AT ALAMEDA TURN RIGHT ONTO ALAMEDA. MAKE ANOTHER RIGHT AT THE NEXT LIGHT WHICH IS WHIPPLE AVE.

CONTINUE PAST SEQUOIA HOSPITAL. MAKE A RIGHT TURN ON THE ROAD JUST PAST THE EMERGENCY ROOM ENTRANCE. CONTINUE ALL THE WAY TO THE BUILDING AT THE TOP OF THE HILL WHICH IS 2900 WHIPPLE. WE ARE LOCATED ON THE FIRST FLOOR.

## Female History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

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

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### History for Present Illness

Please bubble in the appropriate response

- Blood in your urine.....O Yes O No
- Weak, dribbling stream or trouble starting your urine (poor force).....O Yes O No
- Awaken frequently at night to urinate? If yes, how often? \_\_\_\_\_.....O Yes O No
- Burning or pain when you urinate.....O Yes O No
- Back pains.....O Yes O No
- Leakage of urine when coughing, straining, sneezing, or exercising.....O Yes O No
- Leakage of urine if you don't get to the bathroom immediately.....O Yes O No
- Leakage of urine when getting up from a chair.....O Yes O No
- Urinating more frequently than usual? If yes, how often? \_\_\_\_\_.....O Yes O No
- Discharge from the vagina.....O Yes O No
- Kidney or bladder stones.....O Yes O No
- Urinary tract infection.....O Yes O No
- Bedwetting or daytime wetting of clothes.....O Yes O No
- History of sexually transmitted disease(s).....O Yes O No
- Painful intercourse.....O Yes O No
- Skin problems in the genital or groin area.....O Yes O No
- Fertility problems.....O Yes O No
- Have you ever had kidney xrays or ultrasounds performed.....O Yes O No
- Are you currently pregnant or are you actively trying to become pregnant.....O Yes O No

### OB/GYN HISTORY

Have you ever been pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how many times? \_\_\_\_\_

How many vaginal deliveries? \_\_\_\_\_ How many c-section deliveries? \_\_\_\_\_

Date of your last period? \_\_\_\_\_ Date of last Pap smear? \_\_\_\_\_

Have you had a hysterectomy? \_\_\_\_\_

What method do you use to prevent pregnancy? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**Medications**

Please list all prescriptions and over-the-counter medications, vitamins, and herbs you are taking.


Do you have any **ALLERGIES TO MEDICATIONS**?       Yes     No

If yes, what medication(s)? \_\_\_\_\_

Have you ever had a reaction to **X-RAY DYE**?       Yes     No

If yes, what type of reaction? \_\_\_\_\_

Are you allergic to **LATEX**?       Yes     No

Are you 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.):

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**Surgical History**

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

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**Have you ever been hospitalized?**       Yes     No

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

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

### 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? _____		

### Social History

Tobacco Questionnaire:

Do you currently use tobacco products?  Yes  No

If yes, what type and how often? \_\_\_\_\_

If no, have you ever used tobacco products?  Yes  No

If yes, what type and when did you quit? \_\_\_\_\_

Have you used drugs other than those for medical reasons in the past 12 months?  Yes  No

If yes, what type and how often? \_\_\_\_\_

Do you currently drink alcoholic beverages?  Yes  No

If yes, what type and how often? \_\_\_\_\_

Do you currently consume caffeine (this includes chocolate)?  Yes  No

If yes, what type and how often? \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced  Not Answered

How many children do you have? \_\_\_\_\_ Occupation: \_\_\_\_\_

### Past labs

Have you had any lab testing done pertaining to urology (i.e. Urinalysis, Urine culture, etc.)?

If yes, when and where? \_\_\_\_\_

\_\_\_\_\_

### Past X-rays

Have you had any x-rays done pertaining to urology (i.e. ultrasounds, CT's, KUB's, etc.)?

If yes, when and where? \_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

## Review of Systems

### GENERAL

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

### HEAD/EYES/EARS/NOSE/THROAT

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

### RESPIRATORY

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

### CARDIOVASCULAR

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

### GASTROINTESTINAL

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

### NEUROLOGICAL

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

### MUSCULOSKELETAL

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

### ENDOCRINE

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

### SKIN

Change in skin or nail texture       Yes  No      Itching       Yes  No  
Hives       Yes  No      Dry skin       Yes  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:	
<b>PATIENT INFORMATION</b>					
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	Marital status (select one) <input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid
Street address:			City:	State:	Zip Code:
Social Security no.: (required if billing insurance)			Home phone:	Cell phone no.:	
Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Pharmacy Name:	Street/City of your pharmacy:	
Okay to download medication history? <input type="checkbox"/> Yes <input type="checkbox"/> No			Email Address:		
Occupation:		Employer:		Employer phone no.:	
Ethnicity:		Race:		Preferred Language:	
Do you have an Advance Directive : <input type="checkbox"/> Yes <input type="checkbox"/> No if Yes DNR <input type="checkbox"/> Yes <input type="checkbox"/> No Surrogate Decision Maker : <input type="checkbox"/> Yes Name:					
Do you have power of attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, person's name:				Phone Number:	
Spouse's Name (If applicable):			Spouse's date of birth:		
Referred to Sequoia Urology Center by? (please check one box)	<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Insurance Company		<input type="checkbox"/> Family
	Name		<input type="checkbox"/> Hospital <input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Friend <input type="checkbox"/> Website/Internet Search
<b>IN CASE OF EMERGENCY</b>					
Name of local friend or relative:		Relationship to patient:	Home phone no.:	Cell phone no.:	
<b>INSURANCE INFORMATION (Please bring cards with you to appointment)</b>					
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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

# FINANCIAL POLICY

## CASH PATIENTS

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

## HMO / PPO HEALTH PLANS

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- "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

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- 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

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- 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

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- **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):**

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Home Telephone</b> _____<br><input type="checkbox"/> <b>O.K. to leave message with detailed information</b><br><input type="checkbox"/> <b>Leave message with call-back number only</b> | <input type="checkbox"/> <b>Written Communication</b><br><input type="checkbox"/> <b>O.K. to mail to my home address</b><br><input type="checkbox"/> <b>O.K. to mail to my work/office address</b><br><input type="checkbox"/> <b>O.K. to fax to this number</b> _____<br><input type="checkbox"/> <b>Family members authorized to receive medical information</b> _____ |
| <input type="checkbox"/> <b>Cell Phone</b> _____<br><input type="checkbox"/> <b>O.K. to leave message with detailed information</b><br><input type="checkbox"/> <b>Leave message with call-back number only</b>     | <br><br><br>_____  |

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 hereby 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 hereby 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 hereby 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**