

# Peninsula Urology Center, Inc.

Adult and Pediatric Urology \* Male Infertility \* Impotence

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

Welcome to Peninsula 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:

- 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.**

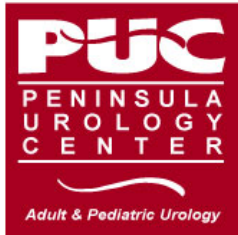
Upon arrival for your appointment, we ask that you check-in with our receptionist. In addition to the completed forms you will be giving her, she will ask for:

- 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.

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 Peninsula Urology Center on \_\_\_\_\_ at \_\_\_\_\_ am / pm; in the following office location:

3351 El Camino Real  
Ste. 101  
Atherton, CA 94027  
Ph:(650) 306-1016 – Fax: (650) 369-3627



**Chris B. Threatt, M.D.**  
**Dieter Bruno, M.D., F.A.C.S.**  
*Diplomate, American Board of Urology*

3351 El Camino Real, Suite 101  
Atherton, California 94027

Phone: (650) 306-1016  
Fax: (650) 369-3627  
Web Site: [puc@pucenter.com](mailto:puc@pucenter.com)

## **DIRECTIONS TO THE ATHERTON OFFICE 3351 EL CAMINO REAL, SUITE 101**

### **HEADING SOUTHBOUND ON 101**

TAKE THE WOODSIDE ROAD EXIT WESTBOUND.  
CONTINUE ON WOODSIDE ROAD UNTIL YOU SEE SOUTH EL CAMINO REAL (IT WILL BE A RIGHT TURN).  
TAKE SOUTH EL CAMINO REAL PAST 4 STOP LIGHTS – STAY IN LEFT LANE.  
AFTER THE FOURTH STOP LIGHT, MAKE THE FIRST LEFT TURN WHICH WILL BE LOYOLA AVENUE.  
WE ARE ON THE CORNER OF LOYOLA AND EL CAMINO REAL.  
YOU CAN PARK ON THE STREET OR IN THE PARKING LOT BEHIND THE BUILDING.

### **HEADING NORTHBOUND 101**

TAKE THE MARSH ROAD EXIT WESTBOUND.  
CONTINUE ON MARSH ROAD UNTIL IT DEAD ENDS AT MIDDLEFIELD.  
TURN RIGHT ON MIDDLEFIELD.  
MAKE THE FIRST LEFT THAT YOU CAN WHICH WILL BE FAIR OAKS.  
CONTINUE ON FAIR OAKS UNTIL YOU COME TO THE STOP LIGHT WHICH WILL BE EL CAMINO REAL.  
TURN RIGHT ON EL CAMINO REAL.  
WE ARE LOCATED APPROXIMATELY 1 MILE DOWN ON THE RIGHT HAND SIDE ON THE CORNER OF LOYOLA AND EL CAMINO REAL.  
YOU CAN PARK ON THE STREET OR IN THE PARKING LOT BEHIND THE BUILDING.

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

TAKE THE WOODSIDE ROAD EXIT EASTBOUND  
CONTINUE ON WOODSIDE ROAD UNTIL YOU SEE SOUTH EL CAMINO REAL (IT WILL BE A RIGHT TURN)  
TAKE SOUTH EL CAMINO REAL PAST 4 STOP LIGHTS – STAY IN LEFT LANE.  
AFTER THE FOURTH STOP LIGHT, MAKE THE FIRST LEFT TURN WHICH WILL BE LOYOLA AVENUE.  
WE ARE ON THE CORNER OF LOYOLA AND EL CAMINO REAL.



## Peninsula Urology Center, Inc.

### 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 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 after insurance payments, you will be responsible for any finance charge or collection charges for this account.

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

#### CANCELLED APPONTMENTS

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- **A \$50.00 charge will be assessed for appointments not canceled with 24 hours prior notice. A \$75.00 charge will be assessed for all procedures not canceled with 24 hours prior notice.**

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Responsible Party Signature

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Dated

**CHRIS THREATT, M.D.  
DIETER BRUNO, M.D., F.A.C.S.  
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 Peninsula Urology Center, Inc. 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><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><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> _____ |
| <input type="checkbox"/> <b>Work Telephone</b> _____<br><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>Family members authorized to receive medical information</b> _____<br>_____<br>_____   |

\_\_\_\_\_  
**Print Patient Name**

\_\_\_\_\_  
**Patient's Birthdate**

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

\_\_\_\_\_  
**Date**

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.

**Record of Disclosures of Protected Health Information**

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

1. Check this box if the disclosure is authorized
2. Type key: T- Treatment Records, P-Payment Information, O-Healthcare Operations
3. Enter how information was released: F-Fax, Ph-Phone, E-email, M-Mail, O-Other

Today's Date: \_\_\_\_\_

**FEMALE PATIENT HISTORY FORM**

**PATIENT'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**PRIMARY CARE PHYSICIAN (FAMILY DOCTOR)** \_\_\_\_\_

**CHIEF COMPLAINT** – What is the main reason for your visit to the urologist today?  
\_\_\_\_\_

How long have you been having this problem? \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

Do you have or have you recently had any of the following listed below? Please circle your response.

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

**OB/GYN HISTORY**

How many times have you been pregnant? \_\_\_\_\_

How many vaginal deliveries? \_\_\_\_\_

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

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

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

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

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

<b>Physician Use Only</b>
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Today's Date: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PAST MEDICAL AND SURGICAL HISTORY**

Serious Medical Illnesses (Check all that apply and provide details below that you feel are important for us to know)

- Heart attack?                       Kidney failure?                       Diabetes? → If yes, do you use insulin? \_\_\_\_\_
- Heart failure?                       Chronic lung disease?                       Cancer? → If yes, what type? \_\_\_\_\_
- Heart valve problem?                       Angina?                       Asthma?                       Peptic ulcers?
- High cholesterol?                       Joint replacement?                       Bleeding disorder?                       Thyroid problems?
- High blood pressure?                       Neurological/Psychiatric problems?                       Other? \_\_\_\_\_

Details \_\_\_\_\_

**PREVIOUS SURGERIES (PLEASE LIST)**

Year	Type	Year	Type

**MEDICATIONS (Please write full dosages)**

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

.....

.....

.....

Do you use any nitroglycerin medications (medicine for chest pain?)  Yes  No

**ALLERGIES TO MEDICATIONS**

NKDA (No known drug allergies)

..... Have you had a reaction to iodine x-ray dye?  Yes  No

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

**SOCIAL HISTORY**

Married     Single     Widowed     Separated     Divorced

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

Tobacco: Packs per week \_\_\_\_\_ Quit \_\_\_\_\_ Quit When? \_\_\_\_\_ Never \_\_\_\_\_

Alcohol: Beer \_\_\_\_\_ /wk    Liquor \_\_\_\_\_ /wk    Wine \_\_\_\_\_ /wk    None \_\_\_\_\_

Caffeine: Coffee/day \_\_\_\_\_ Tea/day \_\_\_\_\_ Chocolate – Yes / No    Soft Drinks w/ caffeine/day \_\_\_\_\_

**FAMILY HISTORY (Write "F" for father, "M" for mother, "S" for sibling)**

- Prostate cancer                       Heart disease
- Kidney cancer                       Lung disease
- Bladder cancer                       High blood pressure
- Kidney failure                       Neurological problems
- Kidney stones
- Other illnesses? \_\_\_\_\_

**Physician use only**

**Today's Date:** \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you currently have any problems related to the areas outlines below? Please circle all that apply.

• **GENERAL**

Weight loss    Loss of appetite    Night sweats    Fatigue    Nausea    Fever    Chills

\_\_\_ *Negative Review*

• **HEAD/EYES/EARS/NOSE/THROAT**

Headaches/Migraines    Hearing problems    Ringing in ears    Nasal congestion    Eye pain  
Dental problems    Dry mouth    Difficulty swallowing    Vision problems    Sore throat

\_\_\_ *Negative Review*

• **RESPIRATORY**

Cough            Phlegm            Bloody Phlegm            Shortness of breath

\_\_\_ *Negative Review*

• **CARDIOVASCULAR**

Chest pain    Irregular heart beat    Leg cramps    Easy breathing

\_\_\_ *Negative Review*

• **GASTROINTESTINAL**

Pain with swallowing    Stomach pain    Vomiting    Bloody stools    Black stools    Constipation  
Diarrhea

\_\_\_ *Negative Review*

• **NEUROLOGICAL**

Numbness    Tremor    Developmental problems    Balance problems    Poor memory

\_\_\_ *Negative Review*

• **MUSCULOSKELETAL**

Weakness    Difficulty walking    Bone or joint pain    Loss of muscle mass

\_\_\_ *Negative Review*

• **ENDOCRINE**

Excessive thirst            Temperature intolerance            Poor growth

\_\_\_ *Negative Review*

• **SKIN**

Change in skin or nail texture    Itchy skin    Hives    Dry skin    Hair loss

\_\_\_ *Negative Review*

<p><b>Physician Use Only</b>  The Patient is currently undergoing evaluation and/or treatment for the items circled above by the following physician:</p> <p>_____</p>
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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_