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

□ 2900 Whipple Ave
Ste. 132
Redwood City, CA 94062
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

2900 Whipple Ave, Suite 132
Redwood City, California 94062
Phone: (650) 306-1016
Fax: (650) 369-3627
Web Site: puc@pucenter.com

DIRECTIONS TO THE REDWOOD CITY OFFICE
2900 WHIPPLE AVE, STE 132

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.
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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.

PENINSULA UROLOGY CENTER, INC.

Chris B. Threatt, M.D. – Dieter Bruno, M.D., F.A.C.S.

Please PRINT and complete ALL sections below **Acct#**

REGISTRATION FORM

PATIENT'S PERSONAL INFORMATION

Name: _____ _____ _____ **Date of Birth:** _____
Last Name **First Name** **Initial**

Address: _____ _____ _____ _____
Street **City** **State** **Zip Code**

Home Phone: _____ **Social Security#** _____- ____- _____ **Sex: M F Marital Status: S M W D**

Occupation: _____**Employer:**_____

Work Phone:_____ **Cell Phone:**_____ **E-Mail:**_____

Ethnicity: _____**Race:**_____**Preferred Language:** _____

If Under 18, Parent's Name or Responsible Party)

Guarantor's Name _____ **Social Security #:**_____-_____-_____

Address: _____ _____ _____ _____
Street **City** **State** **Zip Code**

Home Phone: _____ **Cell Phone:** _____

PRIMARY INSURANCE INFORMATION

Please provide copy of insurance card

Insurance Name:_____ **Insurance Address**:_____

Subscriber ID# _____ **Group #** _____ **Effective Date:** _____

Subscriber Name: _____ **Subscriber's Date of Birth:**_____

Social Security# _____- _____- _____ **Relationship to Patient:** _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Name:_____ **Insurance Address**:_____

Subscriber ID# _____ **Group #** _____ **Effective Date:** _____

Subscriber Name: _____ **Subscriber's Date of Birth:**_____

Social Security# _____- _____- _____ **Relationship to Patient:** _____

PATIENT'S REFERRAL INFORMATION

Primary Care Physician:_____**Referred by:**_____

Address: _____ **City:** _____**State:** _____ **Zip:**_____

Person to Contact In An Emergency: _____**Relationship:**_____

Day Phone: _____**Cell/Evening Phone:** _____

Preferred Pharmacy: _____ **(location)** _____
Do you give us consent to download your medication history? YES / NO

I acknowledge the above information is correct.

Patient Signature (Or Parent, if Minor):_____**Date:**_____

Peninsula Urology Center, Inc.

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 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 or 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 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

- **This office requires a 24-hour notice if you are unable to keep your scheduled appointment. Office visit cancellations of less than 24-hours you will be charged $50.00 and for office procedure cancellations of less than 48-hours you will be charged $75.00.**
  _____Initials

_____ _____

Responsible Party Signature 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):

□ Home Telephone _____

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

□ Work Telephone _____

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

□ Written Communication

- □ **O.K. to mail to my email address** _____
- □ 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, 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 Peninsula Urology Center, Inc. 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 Peninsula Urology Center, Inc. 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 Peninsula Urology Center, Inc. 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. The facilities or centers whereby the physicians have ownership interest may include; but are not limited to:

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS.

_____ _____

Print Patient Name **Patient's Birthdate**

_____ _____

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

Chris Threatt, M.D. *Dieter Bruno, M.D., F.A.C.S.*

Today's Date:_____

MALE 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 **Circle your score for each below**

1-7	Mild
8-19	Moderate
20-35	Severe

Total IPSS Score ☐

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
INCOMPLETE EMPTYING						
• Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
FREQUENCY						
• Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
HESITANCY						
• Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
URGENCY						
• Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
WEAK STREAM						
• Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
STRAINING						
• Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5

	None	1 time	2 times	3 times	4 times	5 times
NOCTURIA						
• Over the last month, how many times did you most typically get up to urinate from the time you went to bed until the time you get up?	0	1	2	3	4	5

BOTHERSOME SCORE	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
• If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

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

- Blood in your urine?► YES NO
- Burning or pain when you urinate?► YES NO
- Discharge from penis?► YES NO
- Fertility problems?► YES NO
- Undescended testicles?► YES NO
- Ever had kidney xrays?► YES NO
- Kidney or bladder stones? YES NO
- Bladder or kidney 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
- Swollen or painful testicles? YES NO
- Skin problems in the genital or groin area? YES NO

Chris Threatt, M.D. ***Dieter Bruno, M.D., F.A.C.S.***

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) **Allergy to Latex? ____ Yes ____ No**

…… …… 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? _____

Chris Threatt, M.D. ***Dieter Bruno, M.D., F.A.C.S.***

Today's Date:_____

PATIENT'S NAME:_____ Date of Birth:_____

REVIEW OF SYSTEMS

Do you currently have any problems related to the areas outlined 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 bruising High/Low Blood Pressure

____*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*

- **LYMPHATIC**

  Inguinal node tenderness

____*Negative Review*

- **CONSTITUTIONAL**: BP_____ T_____P_____ HT_____ WT_____