COAST UROLOGICAL
MEDICAL GROUP

William T. Naftel, M.D. Stephen A. Hightower, M.D. Michael Norris, M.D.
Diplomates, American Board of Urology
Alexa Y. Chai, M.D. Amanda Nelson, PA-C

NEW PATIENT INFORMATION AND INSTRUCTIONS

PLEASE FILL OUT THE ENCLOSED PATIENT INFORMATION SHEET AND THE FRONT AND BACK OF THE PATIENT HISTORY FORM.

IF YOU HAVE HAD PRIOR CONSULTATIONS WITH OTHER UROLOGISTS, PLEASE (IF POSSIBLE) OBTAIN YOUR MEDICAL FILES FROM THESE PHYSICIANS BEFORE YOUR VISIT AND BRING THEM WITH YOU. FROM EXPERIENCE, IT IS FAR MORE RELIABLE TO PICK UP THESE RECORDS THAN RELY ON MAIL DELIVERY.

BILLING AND PAYMENT POLICY:

NOTE: IF APPLICABLE, CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.

MEDICARE PATIENTS:

OUR OFFICE ACCEPTS MEDICARE ASSIGNMENT, AS A COURTESY, WE WILL SUBMIT CHARGES TO MEDICARE.

INSURANCE BILLING:

IF YOU HAVE GIVEN US THE APPROPRIATE INFORMATION, AS A COURTESY, WE WILL SUBMIT CHARGES TO YOUR INSURANCE COMPANY. WITHOUT ADEQUATE INFORMATION, YOU WILL BE RESPONSIBLE FOR ALL CHARGES AT THE TIME OF SERVICE.

SOME INSURANCE PLANS REQUIRE REFERRAL FORMS OR AUTHORIZATIONS FROM YOU PRIMARY CARE PHYSICIAN. IF YOU R PLAN REQUIRES A REFERRAL FORM OR AUTHORIZATION, AND WE RECEIVE IT PRIOR TO YOUR VISIT, YOU WILL ONLY BE REQUIRED TO PAY YOUR CO-PAYMENT AND DEDUCTIBLE. WITHOUT A REFERRAL OR CONFIRMATION OF INSURANCE COVERAGE, YOU WILL BE RESPONSIBLE FOR ALL CHARGES AT THE TIME OF SERVICE.

CO-PAYMENTS ARE ALWAYS REQUIRED AT THE TIME OF SERVICE. WE ACCEPT CASH OR CHECKS WHEN MAKING YOUR CO-PAYMENT; A SERVICE CHARGE WILL BE ASSESSED IF PAYMENT OF CO-PAYMENT IS MADE WITH A CREDIT CARD. WE UNDERSTAND THAT PATIENTS MAY EXPERIENCE FINANCIAL DIFFICULTIES ON OCCASION. IF YOU NEED TO ARRANGE AN EXTENDED PAYMENT PLAN, PLEASE CONTACT OUR PRACTICE MANAGER. WE ACCEPT ALL MAJOR CREDIT CARDS.

PLEASE BRING THESE COMPLETED FORMS WITH YOU TO YOUR SCHEDULED APPOINTMENT, ALONG WITH YOUR INSURANCE CARD AND ANY RECORDS.

DOCTOR: _____

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

3771 Katella Avenue, Suite 210 • Los Alamitos, CA 90720 • (562) 430-0581 • Fax (562) 598-2110
• www.coasturologygroup.com •

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Date: _____

PATIENT HISTORY

WELCOME TO OUR PRACTICE. TO PROVIDE YOU WITH THE BEST CARE POSSIBLE, PLEASE PROVIDE THE FOLLOWING INFORMATION WHICH WILL BE CONFIDENTIAL AND RELEASE ONLY WITH YOUR WRITTEN PERMISSION.

PLEASE PRINT:

Last Name: _____ First Name: _____ Middle Initial: _____

Chief Complaint: _____ Age: _____

Brief History of Problem: _____

_____

_____

LIST THE OPERATIONS YOU HAVE HAD: _____

_____

_____

PAST MEDICAL HISTORY (PLEASE CHECK YES OR NO):

	Yes	No		Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Hypertension	☐	☐	Mumps	☐	☐	Tuberculosis	☐	☐
Stroke	☐	☐	Lung Problems	☐	☐	Liver Disease	☐	☐	Blood in Urine	☐	☐
Ulcers	☐	☐	Female Problems	☐	☐	Pneumonia	☐	☐	Blood Clots	☐	☐
Anemia	☐	☐	Kidney Stones	☐	☐	Asthma	☐	☐	Cancer	☐	☐
Heart Disease	☐	☐	Bleeding Disorders	☐	☐	High Blood Pressure	☐	☐			
Bladder/Kidney Infection	☐	☐									

Have you ever had a serious accident? No _____ Yes _____, Please describe:

_____

_____

Have you ever had a blood transfusion? No _____ Yes _____ If "Yes", what year? _____

(CONTINUED ON SECOND PAGE)

REVIEW OF SYMPTOMS: (CHECK ALL THOSE THAT ARE APPLICABLE)

GENERAL: Fever _____ Chills _____ Weight Loss _____ Weakness _____

SKIN: Rash _____ Itching _____

HEMATOPOIETIC: Bruising _____ Bleeding _____ Anemia _____

HEENT: Vision Change _____ Double Vision _____ Glaucoma _____ Vertigo _____ Hearing Problems _____

RESPIRATORY: Cough _____ Coughing Blood _____ Shortness of Breath _____ Infections _____

CARDIOVASCULAR: Chest Pain _____ Murmurs _____ Pain in Legs with Walking _____ Swelling in the Legs _____

G.I.: Constipation _____ Diarrhea _____ Bleeding _____ Hemorrhoids _____ Indigestion _____ Hepatitis _____

MUSCULOSKELETAL: Joint Pain _____ Weakness _____ Back Pain _____ Cramps _____

NEUROLOGIC: Headache _____ Dizziness _____ Seizures _____ Blackouts _____ Depression _____

Alcohol (aver./day) _____

Caffeine (aver./day) _____ Number of Children _____

Tobacco (aver./day) _____ Recreational Drugs _____

Educational Level _____

FAMILY HISTORY:

Member	Living	Dead	Illness/Cause of Death or State of Health	Any Cancer of Prostate, Diabetes, or Kidney Stones?
Father				
Mother				
Brother				
Brother				
Sister				
Sister				

Is there anything else regarding your health that you would like the Doctor to know?

_____

_____

COAST UROLOGICAL MEDICAL GROUP, INC.

PLEASE PRINT AND COMPLETE ALL SECTIONS

PATIENT'S PERSONAL INFORMATION: MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

HOME ADDRESS: _____ CITY: _____ ZIP CODE: _____

PRIMARY PHONE # ( )_____ SECONDARY PHONE # ( )_____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____ SEX: MALE _____ FEMALE_____

EMAIL: _____

EMPLOYER: _____ OCCUPATION:_____

SPOUSE'S NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____

IF PATIENT IS A MINOR OR STUDENT:

MOTHER'S NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____

[ ] CHECK IF HOME ADDRESS IS SAME AS PATIENT / IF NOT: _____

EMPLOYER: _____ OCCUPATION: _____ CELL PHONE # ( ) _____

FATHER'S NAME: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # _____

[ ] CHECK IF HOME ADDRESS IS SAME AS PATIENT / IF NOT: _____

EMPLOYER: _____ OCCUPATION: _____ CELL PHONE # ( ) _____

PATIENT'S INSURANCE INFORMATION: SPECIALIST CO-PAY: _____ VAS CO-PAY: _____

PRIMARY INSURANCE: _____ INSURANCE ID # _____ GROUP # _____

***PRIMARY POLICY HOLDER:** _____ ***DATE OF BIRTH:** _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER _____ CELL PHONE # ( ) _____

SECONDARY INSURANCE: _____ INSURANCE ID # _____ GROUP # _____

***SECONDARY POLICY HOLDER:** _____ ***DATE OF BIRTH:** _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER _____ CELL PHONE # ( ) _____

ADDITIONAL INFORMATION:

REFERRING PHYSICIAN: _____ PHONE # ( ) _____

PRIMARY CARE PHYSICIAN: _____ PHONE # ( ) _____

ALTERNATE CONTACT: _____ RELATIONSHIP: _____
(Outside of Home)

ADDRESS: _____ PHONE # ( ) _____

PREFERRED PHARMACY: _____ PHONE # ( ) _____

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT:

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Coast Urological Medical Group, Inc., and any assisting physicians, for services rendered. I understand that I am responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits; and agree that a photocopy of this agreement shall be as valid as the original. No guarantees have been made to me regarding the outcome of care.

Date: _____ Signature: _____

Information provided above is still current as of the following date:

Date: _____ Signature: _____

Information provided above is still current as of the following date:

Date: _____ Signature: _____

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PATIENT NAME:		DATE OF BIRTH:	

KNOWN MEDICAL ALLERGIES INCLUDING REACTION:

MEDICATIONS I TAKE (Prescription, non-prescription, vitamins, herbals)

CHANGE	DATE	SIGNATURE
YES NO		
YES NO		
YES NO		
YES NO		
YES NO		
YES NO		

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