Patient Registration Form

(Please Print & Complete in Full)

SKYLINE UROLOGY

MRN: _____

Date: _____

PATIENT INFORMATION

Social Security Number		Email Address
First Name	MI	Last Name
Address		
City	State	Zip

Date of Birth: _____/_____/_____ **Sex**: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Home Number: (____)_____-_____ **Work Number**: (____)_____-_____ **Cell Number**: (____)_____-_____

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Ethnicity: _____ **Preferred Language:** _____

If Patient is a child, lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Name of Person (With Whom Child Lives With): _____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Social Security #: _____-_____-_____**Responsible Party Name**: _____

Address: _____

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

Home Number: (_____)_____-_____ **Work Number**: (_____)_____-_____

Date of Birth: _____/_____/_____ **Sex**: ☐ Male ☐ Female **Relationship**: _____

REFERRED BY:

Referring Physician: _____ **Phone**: (_____)_____-_____

PCP Physician: _____ **Phone**: (_____)_____-_____

IN CASE OF EMERGENCY

Relative/Friend: _____ **Relationship**: _____

Home Number: (_____)_____-_____ **Work Number**: (_____)_____-_____

PHARMACY INFORMATION

Pharmacy (Name, Street Name & Phone Number, if known): _____

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but not limited to co-pays, deductibles, self pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all balances that are not covered by my insurance plan. I also authorize Skyline Urology and the insurance company to release any information required to process my claims. If it becomes necessary to collect fees through the services of an attorney or collection agency, I understand this will increase my balance approximately 30%.

PATIENT SIGNATURE: _____ **DATE:** _____

SKYLINE UROLOGY

SIGNATURE FORM

FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

Patient Name: _____

MRN#: _____

Date: _____

I understand that I am financially responsible to **Skyline Urology** for charges not covered by my insurance carrier. Payment for services is due at time of service unless prior arrangements have been made. I also agree that, should I fail to assume that financial responsibility and credit action is necessary, I will pay for these costs in addition to the amount of the doctor's charges. I authorize **Skyline Urology** to release to the Social Security Administration or its intermediaries or carriers, or other insurance carrier any medical or other information needed for this or a related insurance claim. A copy of this authorization may be used in place of the original.

_____ _____

Date Signature of Patient or Guardian

EXTENDED PAYMENT REQUEST (One Time Authorization) (Medicare and Medicaid Patients ONLY)

I request that payment of authorized Medicare benefits or other insurance benefits be made on my behalf to **Skyline Urology** for any services furnished me by that provider. This one time signature will be maintained on file as verification for all subsequent services which are provided to you by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or other insurance carriers any information needed to determine these benefits or the benefits for related services.

_____ _____

Date Signature of Patient or Guardian

MEDIGAP AUTHORIZATION (Medicare Patients only)

I request that payment of authorized Medigap benefits be made on my behalf to **Skyline Urology** for any services furnished me by that provider. I authorize any holder of medical information about me to

Release to _____ any information needed to determine these benefits
(Name of Medigap Insurer)
Or the benefits payable for related services.

Medicare Number: _____

Secondary Insurance: _____ Policy: _____

_____ _____

Date Signature of Patient or Guardian

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MRN: _____

Patient's Name	
Date	
Age	☐ Married ☐ Single ☐ Widowed ☐ Divorced
Occupation (or former occupation)	

Chief Complaint:

What is the main reason for your visit today? (Please describe in detail)

_____

_____

_____

History of Present Illness:

Location of problem: Abdomen Back Genitals Other: _____	How long does the problem last? 30 minutes 1 day Always there Other: _____
On a scale of 1-10, with 10 being the most severe, circle the number that best describes your problem 1 2 3 4 5 6 7 8 9 10	Is there anything else occurring at the same time? Yes No If Yes, explain _____ Nausea Rash Headache Other: _____
When did you first notice the problem? 2 days ago 1 week ago 1 month ago Other: _____	Is the problem constant or variable? Dull, then sharp Sharp, then leaves Always there Other: _____
Does anything help or make the problem worse? Yes No Moving around Standing Eating	Does the problem interfere with your normal function? Yes No If yes, explain: _____ _____
Physician use (comments and notes)	

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MRN: _____

Patient's Name	Date
Who referred you to this office?	Medical Doctor/PCP
Why are you seeing the physician today?	
When did your problem start?	Pharmacy (Name & Number)

My Main Problems are:

☐ Blood in Urine ☐ Bladder Cancer ☐ Bladder Infection ☐ Bladder Pain
☐ Kidney Stones ☐ Interstitial Cystitis ☐ Leak Urine ☐ Overactive Bladder
☐ Dropped Bladder ☐ Other: _____

Allergies:

☐ None ☐ PCN ☐ Sulfa ☒ Cipro ☐ Iodine/Contrast
☐ Other: _____

Medications: ☐ None ☐ Aspirin ☐ Lortab ☐ Percocet ☐ Plavix ☐ Nitroglycerin
☐ Detrol ☐ Detrol LA ☐ Vesicare ☐ Allopurinol ☐ Coumadin
☐ Antibiotic: _____ ☐ Other: _____

Surgical History: ☐ Appendectomy ☐ Back/Hip/Knee ☐ Bladder Tack ☐ C-Section # _____
☐ Cystoscopy ☐ Gallbladder ☐ Heart Bypass ☐ Hysterectomy ☐ Kidney Stone Surgery
☐ Lithotripsy ☐ Sling (TVT) ☐ Vaginal Deliveries # _____ ☐ Other: _____ ☐ **No Changes**

Medical History: ☐ Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur
☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Last Period: _____ ☐ Menopause
☐ Parkinson's ☐ Pregnant ☐ Strokes ☐ Cancer: _____
☐ Other: _____ ☐ **No Changes**

Family History: ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Smoke: ☐ No ☐ Yes **Occupation:** _____ ☐ Retired

My Symptom(s) are:

General/Constitutional	☐ Fever	☐ Weight Loss	☐ Chills	
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Cataracts	
Ears, Nose, Mouth, Throat	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat	
Cardiovascular	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat	
Respiratory	☐ Shortness of Breath	☐ Wheezing	☐ Chronic Cough	
Gastrointestinal	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels	
Genitourinary	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine	
Musculoskeletal	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles	
Integumentary/Skin	☐ Rash	☐ Persistent Itching	☐ Skin Cancer History	
Neurologic	☐ Numbness	☐ Tingling	☐ Dizziness	
Hematologic/Lymphatic	☐ Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History	

Urinary Symptom(s) are:

☐ Frequency ☐ Urgency ☐ Leakage ☐ Straining ☐ Abdominal Pain
☐ Bladder Pain ☐ Pain in Side R / L ☐ Not Emptying Bladder ☐ Urinating at Night # _____

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Patient's Name	Date
Who referred you to this office?	Medical Doctor/PCP
Why are you seeing the physician today?	
When did your problem start?	Pharmacy (Name & Number)

MRN: _____

My Main Problems are:

☐ Enlarged Prostate ☐ Blood in Urine ☐ High PSA ☐ Bladder Infection
☐ Kidney Stones ☐ Prostate Infection ☐ Urinary Incontinence ☐ Bladder Cancer
☐ Prostate Cancer ☐ Erectile Dysfunction ☐ Overactive Bladder ☐ Infertility
☐ Lump in Testicle ☐ Other: _____

Allergies:

☐ None ☐ PCN ☐ Sulfa ☐ Cipro ☐ Iodine/Contrast
☐ Other: _____

Medications (Please list all current medications):

_____

Surgical History: ☐ Appendectomy ☐ Back/Hip/Knee ☐ Cystoscopy ☐ Gallbladder
☐ Heart Bypass ☐ Kidney Stone Surgery ☐ Lithotripsy ☐ Prostate Biopsy ☐ Prostate Seed
☐ Prostate Surgery ☐ Other: _____ ☐ **No Changes**

Medical History: ☐ Diabetes ☐ Emphysema ☐ Heart Attack ☐ Heart Murmur
☐ Hepatitis ☐ Hernia ☐ Hypertension ☐ Parkinson's ☐ Strokes
Cancer: ☐ Prostate ☐ Kidney ☐ Testis ☐ Other: _____ ☐ **No Changes**

Family History: ☐ Prostate Cancer ☐ Kidney Cancer ☐ Kidney Stones ☐ Heart Disease

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Smoke: ☐ No ☐ Yes **Occupation:** _____ ☐ Retired

My Symptom(s) are:

General/Constitutional	☐ Fever	☐ Weight Loss	☐ Chills	
Eyes	☐ Blurry Vision	☐ Double Vision	☐ Cataracts	
Ears, Nose, Mouth, Throat	☐ Hearing Loss	☐ Nasal Stuffiness	☐ Sore Throat	
Cardiovascular	☐ Chest Pains	☐ Swollen Ankles	☐ Irregular Heartbeat	
Respiratory	☐ Shortness of Breath	☐ Wheezing	☐ Chronic Cough	
Gastrointestinal	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Change in Bowels	
Genitourinary	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine	
Musculoskeletal	☐ Chronic Back Pain	☐ Chronic Neck Pain	☐ Sore Muscles	
Integumentary/Skin	☐ Rash	☐ Persistent Itching	☐ Skin Cancer History	
Neurologic	☐ Numbness	☐ Tingling	☐ Dizziness	
Hematologic/Lymphatic	☐ Swollen Glands	☐ Abnormal Bleeding	☐ Transfusion History	

Urinary Symptom(s) are:

☐ Incomplete Emptying ☐ Frequency ☐ Intermittency ☐ Weak Stream ☐ Straining
☐ Testicle Pain ☐ Pain in Side R / L ☐ Urinating at Night # _____

SKYLINE UROLOGY
3838 West Carson Street, Suite 220, Torrance, California 90503
Phone (424) 212-4594 Fax (424) 288-5222 www.skyuro.com

AUTHORIZATION for RELEASE of PROTECTED HEALTH INFORMATION (PHI)

Read & Complete Entire Document Before Signing

Patient Name:_____ Maiden/Previous Name:_____
Date of Birth:_____ Medical Record # (if known):_____Phone No.:_____
Address:_____
(Street) *(City)* *(State)* *(Zip)*

I authorize the use or disclosure of the above named individual's PHI as described below:

Name, Address and phone number of health provider or entity to release this information:

Name:_____ Phone Number:_____
Address:_____ Fax Number: _____
(Street)
_____
(City) *(State)* *(Zip)*

Description of information to be used or disclosed: Medical Records from :_____ To:_____
Other: (Please specify records and dates:_____
_____

Name, Address and Phone Number of person (s) or organization to whom this information will be sent:

Name:_____ Phone Number:_____
Address:_____ Fax Number: _____
(*Street*)
_____
(City) *(State)* *(Zip)*

This protected Health Information is being used or disclosed for the following purpose:

_____ My personal records _____ For legal purposes, Attorney _____
_____ For other Healthcare Providers _____ Other (please describe)_____

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary. My refusal to sign this authorization will not affect my ability to obtain treatment, except when health services are solely for the purpose of reporting to a third party.
- I may revoke this authorization, in writing, at any time by sending such written notice to Health Care Provider specified above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- Once the information listed above has been disclosed, it may be re-disclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.

This authorization will remain in effect unless you specify a date or event at which time this authorization expires, otherwise it will expire in one year.
Expiration Date or Event:_____

This authorization may include disclosure of the following information only if I place my initials on the appropriate line item below:

_____ HIV related information
_____ Mental health treatment
_____ drug, alcohol, or substance abuse or treatment
_____ communicable diseases (STD)

We will provide your PHI in hardcopy format (fax or hardcopy) unless you specifically request otherwise. If you have records in our electronic health record, you may request an electronic copy of those records and you may request we send an electronic copy of those records to a third party. We will charge you the cost of the electronic media you specify and will report the fee to you upon receipt of your request. Please specify:_____

All items on this form have been completed and my questions about this form have been answered & I have been provided a copy of the form.

Signature of Patient/Guardian:_____**Date:**_____
Photo ID required for records to be picked up. Relationship to Patient:
Witness to ID**:**_____ _____

SKYLINE UROLOGY

PF-3000 (b) NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting your office's Practice Administrator.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

PRINT PATIENT'S NAME **PATIENT MRN NUMBER**

_____ _____

Patient or Legally authorized individual signature Date Time

_____ _____

Printed Name if signed on behalf of the patient Relationship to Patient

(Notation, if any, by staff)

AUTHORIZATION FOR PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

_____ _____

Print Name of person/organization Relationship to Patient

_____ _____

Print Name of person/organization Relationship to Patient