Foothill Urogenital Health
624 W. Duarte Rd, Ste. 203
Arcadia, CA 91007
Alan H. Yamada, M.D. Ben D. Massey III, P.A

Dear Valued Patient,

Welcome to Foothill Urogenital Health, the office of Dr. Alan Yamada, M.D., and Ben Massey, Physician Assistant. We are dedicated to providing you with the highest quality of medical care.

Enclosed you will find our new patient packet. We offer an online registration option for our patient intake forms. Please visit our website www.foothillurogenitalhealth.com. Please be aware that if your patient intake forms are not completed online, or completed prior to your visit, your visit may be delayed. If you wish to complete the forms on paper, please fill out each of the forms and return it to our office on your upcoming visit. Be sure to include a current list of medications and your medical history.

If you should have any questions about completing these forms or about your appointment, please do not hesitate to contact our office at 626-446-8595.

Please call us at least 24 hours in advance to cancel or reschedule your appointment if you are unable to make your original appointment. Otherwise, you will be charged a $45 No Call/No Show Fee.

Thank you,

Alan H. Yamada, M.D.

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WRITTEN ACKNOWLEDGEMENT FORM OF NOTICE OF PRIVACY PRACTICES AND RECORDS RELEASE AUTHORIZATION

I have received a copy of Alan H. Yamada M.D.'s Notice of Privacy Practices.

I hereby give permission to Dr. Alan H. Yamada to release and/or request my medical records to any family, attending physicians, hospital facilities that may be treating me, diagnostic laboratories and/or pharmacies.

Printed Name of Patient _____ Date _____

Signature of Patient _____ Signature of Parent/Guardian if Patient is a Minor _____

ASSIGNMENT OF MEDICARE AND/OR INSURANCE BENEFITS[1]

I request that payment of authorized Medicare Insurance benefits may be made on my behalf to Alan H. Yamada, MD for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the HealthCare Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

PLEASE PRESENT YOUR INSURANCE CARD WITH THIS FORM

☐ **PRIVATE** ☐ **MEDICARE** ☐ **HMO** ☐ **NONE**

Printed Name of Patient _____ Date _____

Signature of Patient _____ Signature of Parent/Guardian if Patient is a Minor _____

[1] Our office is not contracted with Aetna Insurance. For more information, contact the front desk or your insurance.

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Welcome to Our Office! **Today's Date: _____**

First Name:	**M.I.**	**Last Name:**	**Birth date:**	**Sex:** **M F**	**Marital Status** **S M W D**
Street Address:			**Home Phone:**		
City, State, Zip			**Work Phone:**		
Email Address:			**Cell Phone:**		
Social Security #:			**Occupation:**		
Name of Employer:			**Address of Employer:**		

Primary Language:
English Spanish Chinese Korean Japanese Other: Decline

Ethnicity:
Hispanic or Latino Ethnicity Non-Hispanic or Latino Decline to Specify

Race (Please circle all that apply) :
Asian Caucasian African American Pacific Islander Other: Decline

Primary Insurance Company Name:	**Subscriber ID #**	**Group #**
Secondary Insurance Company Name:	**Subscriber ID#**	**Group #:**
Subscriber Name:	**Subscriber Date of Birth:**	**Relationship to Patient:**
Name of Spouse:	**Spouse's Date of Birth:**	**Spouse Social Security #:**
Name of Spouse's Employer		**Spouse's Work #:**
Name of person financially responsible for this account:		**Phone #:**
In case of an Emergency, please contact:	**Relationship to Patient:**	**Phone #:**

Who referred you to our office?	**Primary Medical Doctor:**
Pharmacy Phone #:	**Primary Doctor Phone #**
For Patients under 18 **Mother's Full Name:**	**Father's Full Name:**

PLEASE STATE THE REASON FOR YOUR VISIT :

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Patient Health History

Patient Name: _____ **Today's Date**: _____

DOB: _____

Primary Care Provider: _____ **Pharmacy Phone Number**: _____

Urological History: Indicate if you have been diagnosed with one or more of the following urological conditions

Urological Condition:	No	Yes	List any past surgery and/or treatments
Bladder Cancer			
Kidney Cancer			
Kidney Stones			
BPH/Prostatism (For Males Only)			
Prostate Cancer (For Males Only)			
Other Conditions			

Medical History: Indicate if you have one or more of the following health conditions:

Diabetes I/II	**Yes**	**No**	**High Blood Pressure**	**Yes**	**No**	**High Cholesterol**	**Yes**	**No**
Stroke	**Yes**	**No**	**Heart Attack**	**Yes**	**No**	**COPD**	**Yes**	**No**

Other Conditions

Surgical History: List all previous surgeries as well as an estimate of the date/year

Family History: List any family (grandparents, parents, and siblings)

Cancer?	Strokes?	Heart Attack?	Diabetes?

Social History: Circle and answer all that apply.

Marital Status	Single	Married	Widowed	Divorced	Separated
Do you Smoke?	Never	Current (Year Started _____)		Former (Year Quit _____)	
Do you drink alcohol?	Never	Social	Moderate	Heavy	
Do you Exercise?	Never	Light	Moderate	Daily	

Vitals

Height:	
Weight:	
B/P:	

Patient Name _____

Date of Birth _____

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Review of Systems

Do you CURRENTLY have any problems related to the following systems?

Circle Yes or No. Please explain any Yes answers in the space provided.

Constitutional Symptoms
- Fevers Y N
- Chills Y N
- Headache Y N
- Other: _____

Eyes
- Blurred Vision Y N
- Double Vision Y N
- Pain Y N
- Other: _____

Ear/Nose/Throat/Mouth
- Ear Infection Y N
- Sore Throat Y N
- Sinus Problems Y N
- Other: _____

Cardiovascular
- Chest Pain Y N
- Varicose Veins Y N
- High Blood Pressure Y N
- Other: _____

Respiratory
- Wheezing Y N
- Frequent Cough Y N
- Shortness of Breath Y N
- Other: _____

Gastrointestinal
- Abdominal Pain Y N
- Nausea/Vomiting Y N
- Indigestion/Heartburn Y N
- Other: _____

Genitourinary
- Urine Retention Y N
- Painful Urination Y N
- Urinary Frequency Y N
- Other: _____

Musculoskeletal
- Joint Pain Y N
- Neck Pain Y N
- Back Pain Y N
- Other: _____

Integumentary
- Skin Rash Y N
- Boils Y N
- Persistent Itch Y N
- Other: _____

Neurological
- Tremors Y N
- Dizzy Spells Y N
- Numbness/tingling Y N
- Other: _____

Psychiatric
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide? Y N
- Other: _____

Endocrine
- Excessive Thirst Y N
- Too Hot/Cold Y N
- Tired/Sluggish Y N
- Other: _____

Hematologic/ Lymphatic
- Swollen Glands Y N
- Blood clotting problem Y N
- Other: _____

Allergic/Immunologic
- Hay Fever Y N
- Drug Allergies Y N
- Other: _____

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Current Medications/Allergies

Please list your medications and dosage to the best of your ability.

Medication Name	Dosage

Allergies to medications if NONE please so indicate.
