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 at www.foothillurogenitalhealth.com. **Please be aware that if your patient intake forms are not completed online, or completed prior to the visit, your visit may be delayed.** If you wish to complete the forms and 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.

Should you 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 $50 No Call/No Show Fee.

Thank you,

Alan H. Yamada, M.D.

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Welcome to Our Office!

Today's Date: _____

First Name:	M.I.	Last Name:	Date of Birth:	Sex:

Street Address:	Home Phone:
City, State, ZIP	Work Phone:
Email Address:	Cell Phone:
Name of Employer:	Address of Employer:
Occupation:	

Primary Language:

English Spanish Chinese Korean Japanese 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:
Name of Spouse's Employer:	Spouse's Work #:
Name of person financially responsible for this account:	Phone #:
Emergency Contact:	Phone #:
Relationship to Patient:	
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:** _____

Date of Birth: _____

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

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

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

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

Cancer?	**Strokes?**	**Heart Attack?**	**Diabetes**

Vitals:	**Height:**	**Weight:**	**B/P:**

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Date of Birth _____

REVIEW OF SYSTEMS

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

Check the box ☑ if "**YES**". Please explain any **YES** answers in the space provided.

Constitutional Symptoms

- Fevers ☐
- Chills ☐
- Headache ☐
- Other: _____

Eyes

- Blurred Vision ☐
- Double Vision ☐
- Pain ☐
- Other: _____

Ear/Nose/Throat/Mouth

- Ear Infection ☐
- Sore Throat ☐
- Sinus Problems ☐
- Other: _____

Cardiovascular

- Chest Pain ☐
- Varicose Veins ☐
- High Blood Pressure ☐
- Other: _____

Respiratory

- Wheezing ☐
- Frequent Cough ☐
- Shortness of Breath ☐
- Other: _____

Gastrointestinal

- Abdominal Pain ☐
- Nausea/Vomiting ☐
- Indigestion/Heartburn ☐
- Other: _____

Genitourinary

- Urine Retention ☐
- Painful Urination ☐
- Urine Frequency ☐
- Other: _____

Musculoskeletal

- Joint Pain ☐
- Neck Pain ☐
- Back Pain ☐
- Other: _____

Integumentary

- Skin Rash ☐
- Boils ☐
- Persistent Itch ☐
- Other: _____

Neurological

- Tremors ☐
- Dizzy Spells ☐
- Numbness/Tingling ☐
- Other: _____

Psychiatric

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

Endocrine

- Excessive Thirst ☐
- Too Hot/Cold ☐
- Tired/Sluggish ☐
- Other: _____

Hematologic/Lymphatic

- Swollen Glands ☐
- Blood Clotting Problem ☐
- Other: _____

Allergic/Immunologic

- Hay Fever ☐
- Drug Allergies ☐
- Other: _____

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Patient Name: _____

Date of Birth: _____

Current Medications/Allergies

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

Medication Name	Dosage	Route (oral, injection, etc.)	Frequency

Please list any **allergies** to medications if any. If **NONE**, please leave blank.

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NOTICE OF PRIVACY PRACTICES AND RECORDS RELEASE AUTHORIZATION

I hereby give permission to FOOTHILL UROGENITAL HEALTH to release and/or request my medical records (***only records pertinent to services rendered by Foothill Urogenital Health***) to any family, attending physicians, hospital facilities that may be treating me, diagnostic laboratories and/or pharmacies. The release of records will be a $35 fee upon initial request.

NOTE: We are not able to release records from other physicians or hospital(s) that were sent to our office. Please contact the originator of those records to obtain them.

ASSIGNMENT OF MEDICARE AND/OR PRIVATE INSURANCE BENEFITS

I request that payment of authorized Medicare and/or private insurance benefits be made on my behalf to FOOTHILL UROGENITAL HEALTH for any services rendered to me by the listed provider/supplier. I authorize FOOTHILL UROGENITAL HEALTH to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to FOOTHILL UROGENITAL HEALTH. I hereby authorize those photocopies of this form to be valid as the original.

INSURANCE POLICY, AUTHORIZATION & ASSIGNMENT

Changes made daily among insurance companies, make it impossible for us to accept the responsibility of knowing if your plan dictates benefits, payments coverage and whom you can and cannot see. As a service to you, we will file your insurance claim. For us to file your insurance, **please provide your current insurance information** on the day of your visit. It remains the responsibility of the patient to know his/her own plan.

I request that payment of authorized medical benefits is made on my behalf directly to FOOTHILL UROGENITAL HEALTH, provider of service(s) furnished to me.

PAYMENT GUARANTEE

I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through FOOTHILL UROGENITAL HEALTH medical practice and providers from my first date of examination or treatment. This includes cancellation fees due to no-show or late cancellation after 48 hour policy of your scheduled appointment; I agree to make full payment immediately upon receipt of a FOOTHILL UROGENITAL HEALTH billing statement whether it is an interim or final bill. If I fail to make full payment or fail to comply with other payment arrangements made with FOOTHILL UROGENITAL HEALTH'S approval, I understand that appropriate collection measures may be initiated and/or no further services will be rendered to me.

_____ _____

Printed name of Patient Date

_____

Signature of Patient

_____

Signature of Patient/Guardian if Patient is Minor