David H.C. King, M.D.

Urological Surgeons of Northern Calif. Inc.

Patient Information Sheet (Please Print)

Name: ______________ (First) ______________ (Middle) ______________ (Last)

Address: ______________ (number and street) ______________ (City) ______________ (Zip code)

Birthdate: ______________ Home Phone: ______________ Cell Phone: ______________

Social Security Number: ______________ Email Address: ______________

Gender: ( )Male ( )Female Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Child

Employed by: ______________ Work Phone: ______________

Work Address: ______________ Occupation: ______________

Responsible Party for Payment: ( ) Self ( ) If other than self, then please give information:

Name: ______________ Relation: ______________ Birthdate: ______________

Address: ______________ Phone: ______________

Method of Payment: ( ) MediCare Insurance ( ) Private Insurance ( ) Secondary Insurance ( ) Cash Pay

Please give receptionist any Medicare or Medical Insurance cards to copy for our records

Who is your Primary Care Physician? ______________

Who referred you to our office / How did you find out about our office? ______________

***Please indicate any or all methods we can use to communicate with you regarding your personal health information:**

( ) leave message on home phone ( ) leave message on cell phone ( ) leave message at email address

( ) mail information to home address ( ) fax information to ______________

***Please list your preferred Pharmacy Name and Location:** ______________

***Please list names of any person(s) and their relation to you whom we may discuss your medical information with:**

____

*** PLEASE READ AND SIGN ***

Cancellation/No show Policy: Please notify us more than 24 hours in advance of any appointment changes or cancellations. For a <u>second</u> missed, cancelled, or changed appointment with less than 24 hours notice, there will be a fee of $50.00 for office visits or $100.00 for procedure appointments payable before another appointment is to be made.

Any copayments, deductible fees and cash pay amounts are due and payable at the time of service. For patients with insurance, we will submit your claim to the insurance company. Any remaining balances after insurance processing will be due from the Responsible Party for Payment. Please remember that the ultimate responsibility for knowing coverage of fees for visits, tests, procedures, surgeries are with the patient or Party Responsible for Payment. Unpaid account balances outstanding after 90 days will be subject to an additional monthly finance charge of 1.5% per month.

Signed: ______________ Date: ______________

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in Dr. Manzone's office. Information contained here will not be released to anyone without your authorization.

TODAY'S DATE ____/____/____ DATE OF LAST PHYSICAL EXAM ____/____/____ Chart # ____________

LAST NAME ________________________ FIRST NAME ______________ MIDDLE ____________

Social Security No. ______________ DATE OF BIRTH ____/____/____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

____

____

____

History of Present Illness

Please answer the following questions

Location of the problem Front Back

Abdomen ☐ Back ☐ Leg ☐

Other ______________________

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago ☐ 2 weeks ago ☐ 1 month ago ☐

Other ______________________

Does anything help or make the problem worse?

Moving around ☐ Standing Up ☐ Lying on my side ☐

Other ______________________

How long does the problem last?

30 minutes ☐ 1 hour ☐ It is always there ☐

Other ______________________

Is anything else occurring at the same time?

Yes No If yes, please explain.

Nausea ☐ Rash ☐ Headache ☐

Other ______________________

Is the problem constant or variable?

Dull then Sharp ☐ Very sharp then leaves ☐ Always there ☐

Other ______________________

Does the problem interfere with your normal functions?

Yes No If yes, please explain ______________

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

______________ ______________ ______________

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery Date

____

Are you on any medications? Y N (If yes, list all.)

Are you on a special diet? Y N **If yes, please explain**

Do you smoke? Y N

If yes, how much? ______________

Do you drink? Y N

If yes, how much? ______________

Do you have allergies? Y N (If yes, Please explain.)

Physician use only: (Comments/Notes)

#Answer	Level of Service
0	1 or 2
1 -2	3
3	4 or 5

David King, M.D., 320 Dardanelli Lane, Suite 23b, Los Gatos, Ca. 95032 Tel: 408 866-2500
Domenico J. Manzone, M.D.

LAST NAME ____________ FIRST NAME ____________ Chart # ____________

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

Constitutional Symptoms

- Fever Y N
- Chills Y N
- Headache Y N
- Othe ____________

Eyes

- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other ____________

Allergic/Immunologic

- Hay Fever Y N
- Drug allergies Y N
- Other ____________

Neurological

- Tremors Y N
- Dizzy spells Y N
- Numbness/tingling Y N
- Other ____________

Endocrine

- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other ____________

Gastrointestinal

- Abdominal pain Y N
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Other ____________

Cardiovascular

- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other ____________

Integumentary

- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other ____________

Musculoskeletal

- Joint pain Y N
- Neck pain Y N
- Back pain Y N
- Other ____________

Ear/Nose/Throat/Mouth

- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Other ____________

Genitourinary

- Urine retention Y N
- Painful urination Y N
- Urinary frequency Y N
- Other ____________

Respiratory

- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other ____________

Hematologic/Lymphatic

- Swollen glands Y N
- Blood clotting problem Y N
- Other ____________

Psychologic

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

Physician use only: (Comments/Notes)

#Answer	Level of Service
0-1	1 or 2
2-9	3-4 or
10+	5

Physician: ____________

David King, M.D.
Domenico J. Manzone, M.D.

Date: ____/____/____

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David H.C. King, M.D.
A Division of Urological Surgeons of Northern California, Inc.
Adult and Pediatric Urology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, ____,
(Please Print Name)

have received a copy of this office's notice of privacy practices.

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgment cannot be obtained because:

__ Individual refused to sign

__ Communications barriers prohibited obtaining acknowledgment

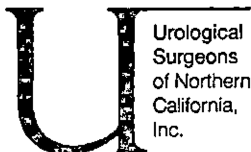
__ An emergency situation prevented us from obtaining acknowledgment

__ Other (please specify): ______________________________

____

____

320 Dardanelli Lane · Suite 23B · Los Gatos, CA 95032
Telephone (408) 866-2500 · Fax (408) 866-2469



Practice Address
Phone: (xxx)xxx-xxxx

ELECTRONIC PAYMENTS AND TOTALTRANSACT

Urological Surgeons of Northern California, Inc. goal is to provide you with the best, most current medical care available in a positive and supportive environment. Today insurance plans are becoming more complicated in how they determine what the medical practice can collect and what the patient actually owes. Insurance plans now have numerous different co-payments and deductibles that are often confusing to their clients and can even elude the smartest medical practice office manager. What a patient actually owes once insurance pays its portion is a function of the individual's co-payment, deductible, maximum out-of-pocket expenses and where the patient falls within this continuum.

In an effort to streamline this system and make it more cost effective for everybody we are asking every patient to provide us with a credit card, HSA debit card, or a voided check at the time of service. Nothing will be charged to your credit card or checking account until the Explanation of Benefits (EOB) returns from your insurance company and we can enter the contractual write-offs and amount paid by your insurance company into our system. The only amount charged to your credit card or checking account will be the PATIENT RESPONSIBILITY portion as defined on your insurance company's EOB (similar to an invoice). The maximum amount charged to your credit card, HSA debit card, or checking account at any one time will be the lesser of your patient responsibility or $250. You will receive an E-MAIL notification with the amount charged to your credit card or deducted from your checking account. This will significantly reduce the costs of repeat statements and collection attempts. As a small business operating on fixed insurance reimbursements with rising costs and expenses, we must do everything possible to reduce the length of time that we extend credit to our patients. Thank you for your cooperation and understanding.

AUTHORIZATION TO CHARGE MY CREDIT CARD, HSA DEBIT CARD, OR CHECKING ACCOUNT FOR THE "PATIENT RESPONSIBILITY" PORTION OF MY INSURANCE PAYMENT

I authorize Urological Surgeons of Northern California, Inc. and TotalTransact, Inc. to charge my credit card, HSA debit card, or my checking account with the balance due (patient responsibility) portion of my insurance explanation of benefits (EOB). I understand that I can dispute the charge at any time with my credit card company or TotalTransact, Inc; however the actual amount of the charge can only be disputed with my insurance company. If I feel the "patient responsibility" portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company. Any change in the EOB by the insurance company will be reflected as a credit or additional charge on my credit card, HSA debit card, or directly in my checking account.

PATIENT NAME: ______________________ SIGNATURE: ______________________

DATE: ______________________ DATE OF BIRTH: ______________________

E-MAIL ADDRESS: ____

Credit Card Account #: ______________________ Expiration Date: ______________

______________________ ☐ Visa ☐ MC ☐ Disc ☐ AMEX