

7014 N. Whitney, Fresno, CA 93720 Telephone: (559) 321-2800 http://www.urologyassociates.net

PATIE	NT I	HIST	ORY	F0	RM
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PATIENT HISTORY	FURIVI NAME:			
	DATE:			
	ACCOL	JNT#:		
WHAT IS THE REASON FO	OR YOUR VISIT?			
□ Blood in urine: □ Visible □ Invisible		☐ BPH/Male urination symptoms		
☐ Elevated PSA		☐ Erectile Dysfunction		
□ Incontinence/Female u	rination symptoms	<ul> <li>□ Infertility</li> <li>□ Urinary Tract Infections</li> <li>□ Vasectomy Consultation</li> </ul>		
☐ Kidney Stones/Bladder	stones/ureteral stones			
$\square$ Abdominal/Flank Pain				
$\square$ Urologic cancer: $\square$ Blace	dder 🗆 Kidney 🗆 Prosta	$te$ $\square$ Other, please specify:		
How long has this problem I	been present?			
		c-rays, urine cultures, blood tests, etc)? If so, which type		
•	• ,	vix, or Coumadin)?   Yes   No		
ALLERGIES				
	nd the reaction that occur	rs:		
FAMILY HISTORY				
Please indicate if anyone in	your immediate family (IND	DICATE RELATIONSHIP) has had any of these conditions:		
☐ <b>Diabetes</b> RELATIONSHIP:	☐ <b>Kidney Stones</b> RELATIONSHIP:	☐ <b>Kidney disease</b> (renal failure) RELATIONSHIP:		
☐ Bladder Cancer RELATIONSHIP:	☐ Prostate Cancer RELATIONSHIP:	Other cancer		
☐ <b>High Blood Pressure</b> RELATIONSHIP:	☐ <b>Heart Disease</b> RELATIONSHIP:	Stroke		
☐ Coronary Artery Disease RELATIONSHIP:	Other	1 (v. 3)		
PAST MEDICAL HISTORY	,	•• :		
		nedical conditions in the past:		
☐ Diabetes:	☐ Kidney Stones	☐ Kidney disease (renal failure)		
☐ Bladder Cancer	□ Prostate Cancer	□ Other cancer		
☐ High Blood Pressure	☐ Heart Disease	□ Stroke		
☐ Coronary Artery Disease UA-11(1)	□ Other			

	. 1					
List and date any previous surgeries yo						
☐ Cholecystectomy (Gall bladder removal)	☐ Appendectomy (appendix removal)	$\square$ Orthopedic joint replacement				
$\square$ Cardiac valvular surgery	$\square$ Cardiac Bypass Surgery	$\square$ Hernia surgery				
□ Previous urologic surgery:						
$\Box$ Other surgeries (please note below):						
	(					
SOCIAL HISTORY						
Do you currently smoke? $\ \square$ Yes $\ \square$ N	lo					
If yes, how many packs a day?	How many years	?				
Have you ever quit smoking? $\ \square$ Yes	□ No					
If yes, when did you quit?						
How many caffeinated beverages do yo	u drink on a daily basis?					
Do you drink alcohol? $\qed$ Rarely $\qed$ 0	ccasionally $\;\square$ Moderately $\;\square$ Hea	vily 🗆 No				
Marital Status: $\square$ Single $\square$ Married	$\square$ Widow $\square$ Divorced					
Children: $\square$ Yes $\square$ No						
If yes, how many? Num	ber of vaginal deliveries?	-				
Are you sexually active? $\ \square$ Yes $\ \square$ N	0					
What is your occupation?						
MEDICATIONS						
What medications do you take regularly	y? Please specify the DOSAGE					
	_					
	<u> </u>					
PHARMACY INFORMATION						
What is your pharmacy of choice?						
City:	Cross-streets:					
Pharmacy phone number:						

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Thank you for taking the time to complete this form so that we may be better able to serve you.

**SURGERIES** 



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## **REVIEW OF SYSTEMS - MALE**

Physician's Signature  Please Indicate whether you are currently experiencing any of the following conditions:  Yes No  Yes No  SKIN  CHANGE IN WART/MOLE  RASH. PERSISTENT INFECTIONS CHILLS PATIGUE PEVER WEIGHT GAIN > 10LBS. WEIGHT GAIN ON THE GAIN SHEAR. WEIGHT GAIN > 10LBS. WEIGH	Name	Account #	Date
Please indicate whether you are currently experiencing any of the following conditions:  Yes No  Yes No  SKIN  GENERAL  PERSISTENT INFECTIONS  CHILLS FATIGUE FATIGUE FEVER  WEIGHT CAIN > 20LBS  WEIGHT CAIN > 20LBS  WEIGHT LOSS > 10LBS  NECK  NECK PAIN.  BUURRED VISION HEADACHE DOUBLE VISION FAINTING / BLACKING OUT FREEQULAR PAINTING FREQUENCY (FREQUENT URBARTON) FREQUENCY URBARTON FREQUENT URBARTON FREAD URBA			
GENERAL PERSISTENT INFECTIONS CHILLS PATIGUE PATIGUE BOILS PATIGUE BOILS PEVER WEIGHT GAIN 2 10LBS WEIGHT GAIN 2 10LBS WEIGHT LOSS 2 10LBS BOILS BURED VISION HEADACHE BOILS PEY PAIN HEADACHE BACK PAIN BOILS CARDIOVASCUL AR CHEST PAIN CHANGE IN HEADACHE BEART TRAIT BLURRED VISION HEADACHE BACK PAIN BOILS CARDIOVASCUL AR CHEST PAIN CHANGE IN HEART BEAT BRIGHT TON BRIGHT THE EARS BACK PAIN BOILS CARDIOVASCUL AR CHEST PAIN BRIGHT BEAT BEAT BRIGHT BRIGHT BRIGHT BEAT BRIGHT B		cing any of the following conditi	ions:
SKIN  CHILLS CHILLS FATIGUE FEVER WEIGHT GAIN > 10JBS. WEIGHT LOSS > 10JBS. HEENT BLURRED VISION. HEADACHE DOUBLE VISION EAR INFECTION. EAR INFECTION. EAR INFECTION. RINGING IN THE EARS. SINUS PAIN. SORE THROAT.  CHANGE IN BOULS  RESPIRATORY COUGH. WHEEZING DIFFICULTY BREATHING DIFFICULTY BREATHING DIASTROINTESS DIASTROINTESS DIASTROINTESS DIASTROINTESS DIASTROINTESS DIASTROINTESS DERESSION INSORNIA.  MUSCULOSKELETAL BACK PAIN. JOINT PAIN. MUSCULOSKELETAL BACK PAIN. JOINT PAIN. SWELLINGS DEPRESSION INSONNIA. SWELLINGS DEPRESSION INSONNIA. SWELLINGS DIASTROINTESS DIAS			
PERSISTENT INFECTIONS CHILLS CHILLS CHILLS PATIQUE PEVER WEIGHT GAIN > 20LBS. WEIGHT GAIN > 10LBS. WEIGHT LOSS > 1	Yes No	0	Yes No
PERSISTENT INFECTIONS CHILLS CHILLS CHILLS PATIQUE PEVER WEIGHT GAIN > 20LBS. WEIGHT GAIN > 10LBS. WEIGHT LOSS > 1	GENERAL	SKIN	
CHILLS FATIGUE FEVER WEIGHT GAIN > 10LBS WEIGHT LOSS > 10LBS  NECK MEIGHT LOSS > 10LBS  NECK BLURRED VISION HEADACHE CYE PAIN EAR INFECTION. EAR INFECTION. EAR INFECTION. EAR INFECTION. SORE THROAT.  RESPIRATORY COUGH. WHEEZING. DIFFICULTY BREATHING  GASTROINTESTINAL ABDOMINAL PAIN. DIARRHEA HEARTBURN. DI	5.5	7	LE
FATIGUE FEVER WEIGHT GAIN > 10LBS. WEIGHT GAIN > 10		7	
WEIGHT GAIN > 10 DISS.  WEIGHT LOSS > 10 DISS.  HEENT  BLURED VISION. HEADACHE. DOUBLE VISION. HEADACHE. PAINE EAR INFECTION. RINGING IN THE EARS. HAYFEVER. SINUS PAIN. SORE THROAT.  RESPIRATORY COUGH. WHEEZING. DIFFICULTY BREATHING.  GASTROINTESTINAL HEADAGHE IN DIAWARE IN URINARY STREAM. CHANGE IN BOWEL HABITS. CONSTIPATION. DIARRHEA. HEARTBURN. HEARTBURN. HOSCULOSKELETAL BACK PAIN. BOMINIA. BOMINIA.  MUSCULOSKELETAL BACK PAIN. BOMINIA. BOMINIA.  MUSCULOSKELETAL BACK PAIN. BOMINIA. BILODO CLOTS. BOMINIA. BOMI	FATIGUE	7	
MEIGHT LOSS > 10LBS.    NECK PAIN.	FEVER		
HEENT BLURRED VISION HEADACHE DOUBLE VISION HEADACHE BACREDON EYE PAIN EYE PAIN RINGING IN THE EARS HAYFEVER SINUS PAIN SORE THROAT.  GASTROINTESTINAL ABDOMINAL PAIN DIARRHEA ABDOMINAL PAIN NIDIGESTION DIARRHEA NIDIGESTION DIARRHEA NIDIGESTION  MUSCLE PAIN DIOTY PAIN DIARRHEA DIARR	WEIGHT GAIN > 10LBS	NECK	
BLURED VISION   CARDIOVASCULAR   CHEST PAIN   CHEST PAIN	WEIGHT LOSS > 10LBS	NECK PAIN	
BLURRED VISION   CARDIOVASCULAR   HEADACHE   DOUBLE VISION   FAINTING / BLACKING OUT   EYE PAIN   FAINTING / BLACKING OUT		SWOLLEN GLANDS	
HEADACHE DOUBLE VISION   FAINTING / BLACKING OUT   IRREGULAR HEART BEAT   PAINTING / BLACKING OUT   IRREGULAR HEART BEAT   BLACKING OUT   IRREGULAR HEART BLACKING OUT   IRREGULAR HEART BEAT   BLACKING OUT   IRREGULAR HEART BLACKING		CARDIOVASCULAR	
DOUBLE VISION			
EYE PAIN EAR INFECTION. EAR INFECTION. EAR INFECTION. EICHARDE SURE EICHARD BLOOD PRESSURE EICHARD BWELLING  MALE GENITOURINARY BLOOD IN URINE CHANGE IN URINARY STREAM.  ERQUENCY (FREQUENT URINARION).  EICHARDE IN URINARY STREAM.  ERQUENCY (FREQUENT URINARION).  EICHARDE IN URINARY STREAM.  ERQUENCY (FREQUENT URINARION).  EICHARD IN URINARY STREAM.  ERQUENCY (FREQUENT URINARION).  ERQUENCY (FREQUENT URINARION).  EICHARD IN URINARY STREAM.  ERQUENCY (FREQUENT URINARION).  ERGUENCY (FREQUENT U		=	
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RINGING IN THE EARS. HAYFEVER SINUS PAIN. SORE THROAT.  RESPIRATORY COUGH. WHEEZING. DIFFICULTY BREATHING.  GASTROINTESTINAL ABDOMINAL PAIN. CONSTIPATION. DIARRHEA HEARTBURN. INDIGESTION. DIARRHEA HEARTBURN. INCONTINEARS. DIARRHEA HEARTBURN.			
HAYFEVER			
SINUS PAIN. SORE THROAT			
SORE THROAT  RESPIRATORY COUGH			
MALE GENITOURINARY   BLOOD IN URINE   BLOOD IN URINATS   BLOOD CLOTS   BROOM   BROOM IN IN IN URINATY BLOOD IN URINATS   BLOOD CLOTS   BROOM IN INFORMANCE   BLOOD CLOTS   BROOM INFORMANCE   BLOOD CLOTS   BROOM IN INFORMANCE   BLOOD CLOTS   BROOM INFORMANCE   BROOD CLOTS   BROOM INFORMANCE   BROOD CLOTS   BROOD CLO		7	
COUGH WHEZING DIFFICULTY BREATHING  GASTROINTESTINAL ABDOMINAL PAIN CHANGE IN BUNINARY STREAM FREQUENCY (FREQUENT URINATION) IMPOTENCE (SEXUAL DYSFUNCTION) IMPOTENCE (SEXUAL DYSFUNCTION) IMPOTENCE (SEXUAL DYSFUNCTION) INCONTINENCE (LOSS OF BLADDER CONTOL) INCONTINE (LOSS OF BLADDER CON	SORE INVAL	SHORTNESS OF BREAT	<u> </u>
WHEEZING DIFFICULTY BREATHING  GASTROINTESTINAL  ABDOMINAL PAIN CHANGE IN BOWEL HABITS CHANGE IN URINARY STREAM  IMPOTENCE (SEXUAL DYSFUNCTION).  IMPOTENCE (SEXUAL DYSFUNCTION).  INCONTINENCE (LOSS OF BLADDER CONTROL).  NOCTURIA (WAKING UP TO URINATE).  PAINFUL URINATION.  PENILE LESIONS.  TESTICULAR MASS.  TESTICULAR MASS.  TESTICULAR MASS.  URETHRAL DISCHARGE.  URETHRAL DISCHARGE.  URENCY.  URINARY RETENTION.  NEUROLOGICAL  NUMBNESS.  SWELLING OF EXTREMITIES.  PSYCHIATRIC  ANXIETY.  MENTAL ILLNESS.  DEPRESSION.  INSOMNIA.  PANIC ATTACKS.  ENDOCRINE  APPETITE CHANGES.  COLD INTOLERANCE.  ENLORGE SEXUAL DYSFUNCTION).  IMPOTENCE (SEXUAL DYSFUNCTION).  IMPOTENCE (SEXUAL DYSFUNCTION).  IMPOTENCE (SEXUAL DYSFUNCTION).  INPOTENCE (SEXUAL DYSFUNCTION).  IMPOTENCE (SEXUAL DYSFUNCTION).  IMPOTENCE (SEXUAL DYSFUNCTION).  INPOTENCE (SEXUAL DYSFUNCTION).  INPOTENCE (SEXUAL DYSFUNCTION).  IMPOTENCE (SEXUAL DYSFUNCTION).  IMPOTENCE (SEXUAL DYSFUNCTION).  INPOTENCE (SEXUAL DYSFUNCTION).  INPOTENCE (SEXUAL DYSFUNCTION).  INPOTENCE (SEXUAL DYSFUNCTION).  IMPOTENCE (SEXUAL DYSFUNCTION).  INCONTINE (LOS OF EACH TORINTAL URINTAL URI	RESPIRATORY	<b>MALE GENITOURINARY</b>	
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MPOTENCE (SEXUAL DYSFUNCTION)	DIFFICULTY BREATHING	CHANGE IN URINARY S	STREAM
ABDOMINAL PAIN CHANGE IN BOWEL HABITS CONSTIPATION DIARRHEA HEARTBURN. HEARTBURN. INDIGESTION NAUSEA VOMITING  MUSCULOSKELETAL BACK PAIN. JOINT PAIN. JOINT PAIN. SWELLING OF EXTREMITIES  PSYCHIATRIC ANXIETY MENTAL ILLRESS DEPRESSION INSOMNIA PANIC ATTACKS  ENDOCRINE APPETITE CHANGES COLD INTOLERANCE EXCESSIVET THIRST. INCONTINENCE (LOSS OF BLADDER CONTROL). NOCTURIA (WAKING UP TO URINATE). NOC	O A CEROLINIE CERTIFICATION AND A CERTIFICATIO	FREQUENCY (FREQUENT	URINATION)
CHANGE IN BOWEL HABITS		IMPOTENCE (SEXUAL DY	SFUNCTION)
NOCTORIA (WARINE WITH TOWN ADDRESS AND ATTEMPT OF THE PAIN FULL URINATION ADDRESS AND ATTEMPT OF THE PAIN ADDRESS AND ATTEMPT ADDRESS AND AD		INCONTINENCE (LOSS O	F BLADDER CONTROL)
DIARRHEA		NOCTURIA (WAKING UP T	70 URINATE)
HEARTBURN		PAINFUL URINATION	
INDIGESTION		PENILE LESIONS	
NAUSEA		TESTICULAR MASS	
WUSCULOSKELETAL  BACK PAIN.  JOINT PAIN.  SWELLING OF EXTREMITIES  PSYCHIATRIC  ANXIETY  MENTAL ILLNESS.  DEPRESSION.  INSOMNIA.  PANIC ATTACKS  ENDOCRINE  APPETITE CHANGES.  COLD INTOLERANCE.  EXCESSIVE THIRST.  HEAD URGENCY.  URINARY RETENTION.  NEUROLOGICAL  NUMBNESS.  DECREASED MEMORY.  DIZZINESS.  DECREASED MEMORY.  DIZZINESS.  UISUAL CHANGES.  VISUAL CHANGES.  ABNORMAL BLEEDING.  ANEMIA.  BLOOD CLOTS.  ENLARGED LYMPH NODES.		TESTICULAR PAIN	📙 💆
NUSCULOSKELETAL	, ,		
BACK PAIN			
JOINT PAIN	MUSCULOSKELETAL	URINARY RETENTION.	
MUSCLE PAIN SWELLING OF EXTREMITIES  PSYCHIATRIC ANXIETY	BACK PAIN	NEUDOLOGICAL	
DECREASED MEMORY   DIZZINESS	JOINT PAIN		
DIZZINESS   DIZZ			
PSYCHIATRIC ANXIETY	SWELLING OF EXTREMITIES		
ANXIETY			
MENTAL ILLNESS			
DEPRESSION			
INSOMNIA UNSTEADINESS UNSTEADINESS UNSTEADINESS UNSTEADINESS UNSUAL CHANGES UNSUA	· — —		
PANIC ATTACKS VISUAL CHANGES VISUAL CHANGES HEMATOLOGY  APPETITE CHANGES ABNORMAL BLEEDING ANEMIA NAME ANEMIA BLOOD CLOTS BLOOD CLOTS BLOOD CLOTS ENLARGED LYMPH NODES BLOOD CLOTS BLOOD C			
ENDOCRINE  APPETITE CHANGES			
APPETITE CHANGES ABNORMAL BLEEDING ABNORMAL BLEEDING ANEMIA ANEMIA BLEEDING BLOOD CLOTS BL			
COLD INTOLERANCE	ENDOCRINE	HEMATOLOGY	
EXCESSIVE THIRST	APPETITE CHANGES	ABNORMAL BLEEDING	ì 📙 🖳
HEAT INTOLERANCE	COLD INTOLERANCE		
THYROID PROBLEMS BLOOD CLOTTING PROBLEMS			
	THYROID PROBLEMS	BLOOD CLOTTING PRO	BLEMS

	NARAYANA S. AMBATI, M.D.
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□ PAUL GREWALL, M.D.
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☐ ROBERT IULIAN, M.D.

☐ YUK-YUEN LEUNG, M.D.
☐ WILLIAM SCHIFF, M.D.
☐ JAMIE DIPIETRO, D.O.
☐ BENJAMIN STEINBERG, D.O.



# PATIENT REGISTRATION (PLEASE PRINT)

	Patient:Last Name	First Name			Middle Name
	Home Phone: Daytime Phone:	Cell Phone:		Pager:	
NO	Street Address:				
Ϋ́			_		
₽.E	City: State:	Zip:			
E	Sex: DM DF Age:Birthdate:	□ Single □ Marrie	ed 🗆 Widowed 🗅	Separated	Divorced
δŌ	-	_			
	Social Security #:	Driver's License #:		_	
	Patient Employed By:	Bu	usiness Phone #:		
	Reference Physicians	Primary Physic	nian:		
	Referring Physician:Full Name	Filliary Fhysic		Full Name	е
ш_	Responsible Party (if Patient is a minor):		Relationship to	Patient:	
M N	Address:	City: S	State:	Zip:	
	Ocatal Ocaca to the	Deise de Nicesco Mi	Right Date:		
ŽΖ	Social Security #:	Driver's License #:	Birth Date:		
PO RM	Employer:		Occupation:		
	Business Address:		Dav/Business F	Phone #:	
జ			•		
ÜΪ	Spouse: Social S	Security #:	Driver's Licens	e #:	Birth Date:
US T	Employed By:		Occupation:		
O H	Business Address:		Day/Business I		
SP P.		TRELATIONSHIP		TELEPHONE	
	THE ONDE OF EMERICATION (NEDSTIVE OF THE ITE)	The strong stron			
ONSEN	I hereby give consent to release or obtain information of treatment. I understand that I am financially responsible for any legal fees incur	onsible to the above named of	office for the service	es rendered. In the date of s	In the event of collection signature.
	Patient / Responsible Party Signature		Date	/ Date	/ Date
GNMENT	I hereby authorize payment directly to the attending physician of any medical/surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent for release to authorized person of financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.				
ASSI					
⋖	Patient / Responsible Party Signature		Date	Date	Date
	Name of Primary Insurer:				
VSURANCE FORMATION	,				
SE	Address:				
ĕ₹	Policy #:	Group #:	Subscriber	:	
E E	Name of Secondary Insurer (if any):				
SP					
= =	Address:				
	Policy #:	Group #:	Subscriber	r:	
A N	☐ Medicare ☐ MediCal Claim ID #:				
άĚ	Medicare Secondary Payer Information:				
Are you covered by a medical insurance plan where you work?					
E E	Are you covered by a medical insurance plan fror	m your spouse's employer?	☐ Yes	□ No	
် မ					
MEDICARE/MEDI-CAL INFORMATION	Do you have any medical insurance, other than N	Medicare? □ Yes	□ No		
	Is that Medicare supplemental insurance?	□ Yes □ No			



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# HIPAA Patient Signature Log

Privacy Officer Telephone: (559) 321-2873

## To our patients:

All physicians and medical providers are required by law to provide to each patient, a copy of their Notice of Privacy Practices (NPP). This law, also requires us to document that we have given you a copy or have offered to you a copy.

Patient's	Name:		Accour	nt #:	<del></del>	_
Date	Patient Signature	Received Copy	Declined Copy	Declined to Sign	Staff Initial	
						_
						_
						_
						_
						_
						_
	<del></del>	<del></del>				_
						_
						_
	<del></del>					_

Note to UACC Staff: If the patient is a minor or if the patient is not able to sign, then a guardian should sign.

Urology Associates Of Central California Medical Group, Inc.

Staff should 'write in' by the signature, 'guardian'.

Narayana S. Ambati, M.D. Kuldip Behniwal, M.D. Gilbert Dale, M.D. Paul Grewall, M.D. Christopher Julian, M.D. Robert Julian, M.D. Yuk-Yuen Leung, M.D. William Schiff, M.D.

Jamie DiPietro, D.O. Benjamin Steinberg, D.O.



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## REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATION FOR PROTECTED HEALTH INFORMATION (PHI)

#### Policy:

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), individuals have the right to request reasonable alternative means of communications from health care providers in order to ensure confidentiality. It is important to ensure that individuals can receive communications regarding their Protected Health Information (PHI) in a means and location that the individual feels is safe from unauthorized use or disclosure. Urology Associates of Central California (UACC) will accommodate reasonable requests by individuals to receive communications of PHI from the UACC covered health care providers by alternative means or at alternative locations.

#### Procedure:

- 1. Patients must request alternative means of confidential communications in writing, using this form Request for Alternative Means of Communication. Reasonable requests include using alternative telephone numbers, alternative addresses, and allowing leaving messages of PHI on answering machines.
- 2. UACC covered health care providers will not require any explanation from the individual of the reason for the request as a condition of providing alternative communications on a confidential basis.
- 3. Knowledge of a violation or potential violation of this policy must be reported directly to the UACC HIPAA Privacy Officer, at 559-321-2873.

Patient Name:	Account #:
DOB:	Primary Provider:
Preferred Phone Number:	Contact Name:
I authorize UACC to leave messages of Appointment Information	n my answering machine/voicemail for the following:  Treatment Information Medical Results
I authorize UACC to call the folloinformation, treatment information, and	owing location (i.e., nursing home) to discuss appointment d medical results:
Type of Location:	Name of Location:
Contact Name:	Contact Phone Number:
Patient/Guardian Signature	