ORANGE COUNTY UROLOGY ASSOCIATES, INC.

A Medical Group

Don T. Bui, M.D. • Fuad Elkhoury, M.D. • Tammy S. Ho, M.D. • Moses Kim, M.D., Ph.D. • James P. Meaglia, M.D. • Patricia Mwesigwa, M.D. • Leah Y. Nakamura, M.D. • Josh M. Randall, M.D. • Karan J. Singh, M.D. • Aaron Spitz, M.D. • Daniel Su, M.D.• Neyssan Tebyani, M.D.

Patient Name: _____ Birth Date: _____
Last First MI

Sex: *(circle one)* M F Social Security #_____ Drivers License#_____

Address_____ City_____ State_____ Zip_____

Home # _____Cell # _____ Work # _____

E-mail Address _____

Preferred means of communication (circle one) Cell Phone Home Phone Email USPS Mail Any None

Primary Physician_____

Referring Physician_____

Other Physician(s) involved in your care _____

Marital Status ***(Circle one)*** **S M D W**

Spouse's Name_____

Spouse Phone#_____

Employer _____

Occupation _____

Pharmacy Name_____

Phone #_____

Pharmacy *(Street, City)* _____

Emergency Contact ***(other than spouse)*** _____ Relation to you_____ Phone # _____

Race ***(circle one)*** • African-American/Black • Asian • Asian/Pacific Islander • Chinese • Korean • Native Hawaiian • Native American/Alaskan Native • Vietnamese • White • Other_____ • Decline to State

Ethnicity ***(circle one)*** • Hispanic/Latino • Non-Hispanic/Non-Latino

Language Choice ***(circle one)*** • English • Spanish • Chinese • Tagalog • Vietnamese • Korean • Farsi Other_____

RESPONSIBLE PARTY –If other than self or you are a minor.

Name: _____ Relationship:_____

Address_____ City_____ State_____ Zip_____

Home #_____ Work #_____ S.S. #_____

MEDICAL INSURANCE (please present insurance cards for us to photocopy)

Primary Insurance Company: _____ Subscriber's Name_____

Subscriber's Relationship to Patient _____

Insured's ID#_____ Group #_____ Medicare #_____

Secondary Insurance Company: _____ Subscriber's Name_____

Subscriber's Relationship to Patient_____

Insured's ID#_____ Group #_____ Medicare #_____

PLEASE BE ADVISED THAT YOU WILL RECEIVE SEPARATE BILLS FOR ANY LAB TESTS, X-RAYS, ETC. THAT MAY BE ORDERED FOR YOU, AS THEY ARE DONE BY AN OUTSIDE SOURCE.

Assignment of Benefit-Financial Agreement

Assignment and Release. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I hereby assign my benefits to be paid directly to my physician and any assisting physicians. I understand a monthly service fee will be charged on all balance 61 days and older. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I authorize this provider to release any information required to process this claim to my insurance company.

Date:_____ Your Signature X_____

THANK YOU FOR YOUR CAREFUL COMPLETION OF THIS IMPORTANT FORM

Revised 6/16/14

ORANGE COUNTY UROLOGY ASSOCIATES, INC.

A Medical Group

PF-2000 Acknowledgement of Receipt of Notice of Patient Privacy

Orange County Urology Associates, Inc. reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practice of Orange County Urology Associates, Inc.

_____ _____

Signature of Patient *Name of Patient **(Please Print)***

_____ _____

Date *Patient Date of Birth*

Preferred/Secure Phone Options: ☐ **Yes** ☐ **No**

If yes, Please provide a phone number in which we may leave a message on your voicemail with your personal health information. ❒Home ❒Cell ❒Work

Phone#:_____

Expanded Medical Release Option: **Please note: This is Valid for 1 Year**

Please list any person(s) you would like to authorize to have access to your billing, appointments or health information.

*** Such as a Spouse, Parents, Family Members, and/or Friends*.

*** With the exclusion of information that is protected under State or Federal law*

Name **Relationship**

_____ _____

_____ _____

Signature of Patient/Representative **Relationship of Patient Representative**

*** Please note that State Federal law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor*

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Patient Name: _____ Birth Date: _____
Last First MI

Sex: *(circle one)* M F Social Security #_____ Drivers License#_____

Address_____ City_____ State_____ Zip_____

Home # _____Cell # _____ Work # _____

E-mail Address _____

Preferred means of communication (circle one) Cell Phone Home Phone Email USPS Mail Any None

Primary Physician_____

Referring Physician_____

Other Physician(s) involved in your care _____

Marital Status ***(Circle one)*** **S M D W**

Spouse's Name_____

Spouse Phone#_____

Employer _____

Occupation _____

Pharmacy Name_____

Phone #_____

Pharmacy *(Street, City)* _____

Emergency Contact **(*other than spouse*)** _____ Relation to you_____ Phone # _____

Race ***(circle one)*** • African-American/Black • Asian • Asian/Pacific Islander • Chinese • Korean • Native Hawaiian • Native American/Alaskan Native • Vietnamese • White • Other_____ • Decline to State

Ethnicity ***(circle one)*** • Hispanic/Latino • Non-Hispanic/Non-Latino

Language Choice ***(circle one)*** • English • Spanish • Chinese • Tagalog • Vietnamese • Korean • Farsi Other_____

RESPONSIBLE PARTY –If other than self or you are a minor.

Name: _____ Relationship:_____

Address_____ City_____ State_____ Zip_____

Home #_____ Work #_____ S.S. #_____

MEDICAL INSURANCE (please present insurance cards for us to photocopy)

Primary Insurance Company: _____ Subscriber's Name_____

Subscriber's Relationship to Patient _____

Insured's ID#_____ Group #_____ Medicare #_____

Secondary Insurance Company: _____ Subscriber's Name_____

Subscriber's Relationship to Patient_____

Insured's ID#_____ Group #_____ Medicare #_____

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Assignment of Benefit-Financial Agreement

Assignment and Release. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I hereby assign my benefits to be paid directly to my physician and any assisting physicians. I understand a monthly service fee will be charged on all balance 61 days and older. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I authorize this provider to release any information required to process this claim to my insurance company.

Date:_____ Your Signature X_____

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_____ _____

Signature of Patient *Name of Patient **(Please Print)***

_____ _____

Date *Patient Date of Birth*

Preferred/Secure Phone Options: ☐ **Yes** ☐ **No**

If yes, Please provide a phone number in which we may leave a message on your voicemail with your personal health information. ❒Home ❒Cell ❒Work

Phone#:_____

Expanded Medical Release Option: **Please note: This is Valid for 1 Year**

Please list any person(s) you would like to authorize to have access to your billing, appointments or health information.

*** Such as a Spouse, Parents, Family Members, and/or Friends*.

*** With the exclusion of information that is protected under State or Federal law*

Name **Relationship**

_____ _____

_____ _____

Signature of Patient/Representative **Relationship of Patient Representative**

*** Please note that State Federal law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor*

Orange County Urology Associates – New Patient Information Form (Male)

Name: _____ Today's Date: _____

Age _____ Date of Birth: _____ Who referred you? _____

Office Use Only	
Date	ROS by

Present Illness

In your own words, what medical problem or concern brings you to our office today?

_____

_____

_____

For how long? _____ Degree of Severity 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Current Urinary Symptoms

☐ Incontinence (Involuntary Loss of Urine)
- ☐ with urgency
- ☐ with cough or sneeze
- ☐ Number of pads used per day? _____

☐ Blood in urine
☐ Pain in testicles
☐ Flank Pain
☐ Fevers/Chills

☐ Frequency of urination
- Number of voids during the day? _____
- Number of voids during the night? _____

☐ Urgency
- Number of voids during the day? _____
- Number of voids during the night? _____

☐ Burning/ Painful urination
☐ Urethral discharge

Prior Urological History

☐ Previous prostate surgery: _____
☐ Medication to urinate better
name of drug: _____
☐ Elevated PSA
☐ Prostate Inflammation/Prostatitis
☐ Prostate Cancer
☐ Family history of prostate cancer
Whom? _____
☐ Enlarged Prostate
☐ Bladder infections

☐ Urethral Stricture
☐ Kidney infections/pyelonephritis
☐ Kidney stones
☐ Family history of kidney stones: *Whom?* _____
☐ Hydrocele
☐ Other urinary tract disorder: _____
☐ Sexual Dysfunction (impotence or ED)
☐ Infertility
☐ Premature Ejaculation
☐ Previous Sexually Transmitted Disease's

Please answer the following questions:	**Not at all**	**Less than 1 time in 5**	**Less than half the time**	**About half the time**	**More than half the time**	**Almost always**	
1. How often do you urinate again less than 2 hours after a prior urination?	0	1	2	3	4	5	**F Freq**
2. How often do you find it difficult to postpone urination?	0	1	2	3	4	5	**U Urge**
3. How often do you have a weak urination stream?	0	1	2	3	4	5	**↓ Stream**
4. How often do you push or strain to begin urination?	0	1	2	3	4	5	**S Strain**
5. How often do you find that you stop and start again when you urinate?	0	1	2	3	4	5	**I Interm**
6. How often do you have a sensation of not emptying your bladder after urination?	0	1	2	3	4	5	**PVR**
7. How many times do you typically get up to urinate when you go to bed at night?	None	1 time	2 times	3 times	4 times	5 or more	**N Next**
						TOTAL SCORE	_____/35

Quality of Life due to urinary symptoms	**Delighted**	**Pleased**	**Mostly satisfied**	**Mixed, equally satisfied and dissatisfied**	**Mostly Dissatisfied**	**Unhappy**	**Terrible**
8. How would you feel about spending the rest of your life with your urinary condition just the way it is now?	0	1	2	3	4	5	6

Current Medications: Please list the medication you are currently taking and the dosage if you know it. Exclude vitamins or other supplements but include over the counter medications you take regularly.

Name of Medication	*Dose*	*Times per Day*	*Name of Medication*	*Dose*	*Times per Day*

Allergies ☐ ***NO KNOWN DRUG ALLERGIES***

List medications to which you are allergic. Please describe the reaction.

Drug Name: _____ **Allergic Reaction:** _____

Drug Name: _____ **Allergic Reaction:** _____

Are you allergic to latex? ☐Yes ☐No

Have you had an allergic reaction to IVP dye, iodine, or x-ray contrast? ☐Yes ☐No

Do you require antibiotics to see your dentist? ☐Yes ☐No

Do you have **sleep apnea**? ☐Yes ☐No

Review of Past Medical History Please check previous health problems in the past or active problems at this time. *All conditions should be marked with Yes or No.*

Yes No **Eyes**
- ☐ ☐ Cataracts
- ☐ ☐ Glaucoma
- ☐ ☐ Retinal detachment
- ☐ ☐ Other: _____

Yes No **Ears, Nose, Throat**
- ☐ ☐ Allergic rhinitis
- ☐ ☐ Neck mass
- ☐ ☐ Thyroid disease
- ☐ ☐ Sinusitis
- ☐ ☐ Other: _____

Yes No **Pulmonary**
- ☐ ☐ Asthma
- ☐ ☐ Chronic obstructive lung
- ☐ ☐ Emphysema from smoking
- ☐ ☐ Pneumonia
- ☐ ☐ Pulmonary Edema
- ☐ ☐ Pulmonary Embolism
- ☐ ☐ Sleep Apnea

Yes No **Endocrine**
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid problem

Yes No **Blood disorders**
- ☐ ☐ Anemia
- ☐ ☐ Clotting problems
- ☐ ☐ Leukemia
- ☐ ☐ Lymphoma

Yes No **Neurological/Orthopedic**
- ☐ ☐ Arthritis
- ☐ ☐ Carpal tunnel
- ☐ ☐ Stroke
- ☐ ☐ Fracture

List bones: _____

- ☐ ☐ Chronic migraine/ headache
- ☐ ☐ Spinal disc disease
- ☐ ☐ Parkinson's disease
- ☐ ☐ Seizures
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Other: _____

Yes No **Liver**
- ☐ ☐ Hepatitis

Yes No **Gastrointestinal**
- ☐ ☐ Polyps
- ☐ ☐ Crohn's disease
- ☐ ☐ Pancreatitis
- ☐ ☐ Small bowel obstruction
- ☐ ☐ Diverticulitis
- ☐ ☐ Peptic Ulcer
- ☐ ☐ Gallstone
- ☐ ☐ Hemorrhoids

Yes No **Cardiovascular**
- ☐ ☐ Congestive heart failure
- ☐ ☐ Heart Attack
- ☐ ☐ Elevated Cholesterol
- ☐ ☐ Rhythm disturbances, irregular heartbeat. List what kind _____
- ☐ ☐ Angina
- ☐ ☐ Heart murmur
- ☐ ☐ Hypertension, high blood pressure
- ☐ ☐ Aneurysm
- ☐ ☐ Aortic valve problem
- ☐ ☐ Mitral valve problem
- ☐ ☐ Peripheral vascular problem
- ☐ ☐ Other: _____

Yes No **Psychiatric**
- ☐ ☐ Depression
- ☐ ☐ Bipolar Disease
- ☐ ☐ Anxiety
- ☐ ☐ Other: _____

Yes No **Skin**
- ☐ ☐ Skin cancer
- ☐ ☐ Other: _____

Cancers

List any cancers you have had:

_____

_____

Surgical History. Review this list of surgical procedures. Mark those you have had and write your age or the approximate year of the surgery.

Head and Neck

Yes No Year

- ☐ ☐ _____ Cataracts and Lens Implant
- ☐ ☐ _____ Nasal Septum
- ☐ ☐ _____ Laser eye surgery
- ☐ ☐ _____ Thyroidectomy
- ☐ ☐ _____ Tonsils and Adenoids
- ☐ ☐ _____ Other: _____

Cardiovascular/Thoracic

Yes No Year

- ☐ ☐ _____ Abdominal Aneurysm surgery
- ☐ ☐ _____ Angioplasty
- ☐ ☐ _____ Bypass surgery
- ☐ ☐ _____ Heart valve replacement
- ☐ ☐ _____ Cardiac stent
- ☐ ☐ _____ Carotid artery
- ☐ ☐ _____ Defibrillator implant
- ☐ ☐ _____ Lung resection
- ☐ ☐ _____ Pacemaker
- ☐ ☐ _____ Peripheral vascular procedure
- ☐ ☐ _____ Vein stripping
- ☐ ☐ _____ Other: _____

General/Gastrointestinal

Yes No Year

- ☐ ☐ _____ Appendectomy
- ☐ ☐ _____ Bowel Resection Small
- ☐ ☐ _____ Breast biopsy
- ☐ ☐ _____ Breast removal- mastectomy
- ☐ ☐ _____ Gallbladder removed (Open)
- ☐ ☐ _____ Gallbladder removed (Lap)
- ☐ ☐ _____ Colon Resection
- ☐ ☐ _____ Gastrectomy (stomach removal)
- ☐ ☐ _____ Hemorrhoid procedure
- ☐ ☐ _____ Hernia repair – umbilical
- ☐ ☐ _____ Other: _____

Orthopedic/Neurosurgical

Yes No Year

- ☐ ☐ _____ Arthroscopy - knee
- ☐ ☐ _____ Arthroscopy - shoulder
- ☐ ☐ _____ Carpal tunnel repair
- ☐ ☐ _____ Craniotomy
- ☐ ☐ _____ Fracture – surgical repair
- ☐ ☐ _____ Fracture – closed treatment
- ☐ ☐ _____ Laminectomy (spine) cervical
- ☐ ☐ _____ Laminectomy (spine) lumbar
- ☐ ☐ _____ Total hip replacement
- ☐ ☐ _____ Total knee replacement
- ☐ ☐ _____ Other: _____

Plastic/Reconstructive

Yes No Year

- ☐ ☐ _____ Cosmetic
- ☐ ☐ _____ Hand procedure or repair
- ☐ ☐ _____ Rhinoplasty
- ☐ ☐ _____ Skin tag or lesion
- ☐ ☐ _____ Other: _____

Urologic

Yes No Year

- ☐ ☐ _____ Bladder tumor-transurethral
- ☐ ☐ _____ Urethral injections
- ☐ ☐ _____ Kidney stone – removal with scope
- ☐ ☐ _____ Urethral injections
- ☐ ☐ _____ Kidney stone – lithotripsy
- ☐ ☐ _____ Kidney stone – open
- ☐ ☐ _____ Other: _____

Family History

Deceased relation	Age at death	Cause of death	**Living relation**	Age	Illness

Social History

Occupation? _____ If retired, former occupation? _____

Marital status (optional) ☐ Married ☐ Widowed ☐ Divorced ☐ Single

Number of children? _____ Ages? _____

Smoking Classification

☐ Never smoked

☐ Current smoker How many years? _____ Packs/day _____

☐ Ex-smoker How many years? _____ Packs/day _____

What year did you quit? _____

Alcohol Classification

☐ Never drank

☐ Quit Year you quit _____

☐ Current Drinker Amount you drink ☐ Beer _____ ounces or 6 packs/week

☐ Wine _____ ounces or liters/week

☐ Liquor _____ ounces week

Social Drug Use

☐ Never used

☐ Past or current usage: *describe*_____

Current Review of Systems: Please check any ***active*** problems at this time.

Yes No **Constitutional**
- ☐ ☐ Fever
- ☐ ☐ Chills
- ☐ ☐ Fatigue
- ☐ ☐ Weight loss
- ☐ ☐ Loss of appetite

HEENT

Yes No **Eyes**
- ☐ ☐ Poor vision
- ☐ ☐ Blurry vision
- ☐ ☐ Double vision

Yes No **Ears**
- ☐ ☐ Hearing loss
- ☐ ☐ Ringing in ears

Yes No **Nose**
- ☐ ☐ Nose bleeds
- ☐ ☐ Nasal obstruction

Yes No **Throat, Mouth**
- ☐ ☐ Sore throat
- ☐ ☐ Dentures

Other: _____

Yes No **Cardiovascular**
- ☐ ☐ Chest pain/angina
- ☐ ☐ Palpitations
- ☐ ☐ Swelling of feet/ankles
- ☐ ☐ Shortness of breath/activity
- ☐ ☐ Trouble sleeping w/1 pillow

Other: _____

Yes No **Respiratory**
- ☐ ☐ Cough
- ☐ ☐ Shortness of breath
- ☐ ☐ Wheezing

Other: _____

Yes No **Gastrointestinal**
- ☐ ☐ Jaundice
- ☐ ☐ Abdominal pain
- ☐ ☐ Diarrhea
- ☐ ☐ Nausea/Vomiting
- ☐ ☐ Bloody or black stools
- ☐ ☐ Constipation
- ☐ ☐ Pancreatitis
- ☐ ☐ Peptic ulcers

Other: _____

Yes No **Musculoskeletal**
- ☐ ☐ Backache
- ☐ ☐ Joint pain
- ☐ ☐ Muscle aches

Other: _____

Yes No **Neurological**
- ☐ ☐ Tremors
- ☐ ☐ Numbness
- ☐ ☐ Dizziness
- ☐ ☐ Headaches
- ☐ ☐ Fainting

Yes No **Psychiatric**
- ☐ ☐ Nervousness
- ☐ ☐ Hallucinations
- ☐ ☐ Anxiety
- ☐ ☐ Depression

Yes No **Endocrine**
- ☐ ☐ Hot flashes
- ☐ ☐ Excessive thirst/sweating
- ☐ ☐ Hot or cold intolerance

Other: _____

Yes No **Skin**
- ☐ ☐ Sores
- ☐ ☐ Rash
- ☐ ☐ Itching

Other: _____

Yes No **Hematologic/Lymphatic**
- ☐ ☐ Easy bruising/bleeding
- ☐ ☐ Swollen lymph nodes/glands

Other: _____

Yes No **Allergic/Immunologic**
- ☐ ☐ Rash
- ☐ ☐ Hives

Other: _____

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of a very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with you doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for each question.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?

Very low	Low	Moderate	High	Very High
1	2	3	4	5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?

No sexual activity	Almost Never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?

Did not attempt sexual activity	Almost Never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?

Did not attempt sexual activity	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
0	1	2	3	4	5

5. When you attempted sexual intercourse, how often was it satisfactory for you?

Did not attempt sexual activity	Almost Never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
0	1	2	3	4	5

Score: _____

Orange County Urology Associates, Inc.
Financial Policy

Welcome to Orange County Urology Associates, Inc. Your initial visit can range from $200 to $500. Here are some guidelines to help you get your insurance information ready for your visit:

MEDICARE

- Do you have a supplemental plan?
  - YES – We will bill both insurances on your behalf. You will be billed for any balance owed by you after the insurances have paid their amounts.
  - NO –
    i. Have you met your deductible? If not; (2014: $147 Part B)
    ii. You will be required to pay your co-insurance percentage and any portion of the deductible that has not been met at check in.

PPO PLAN

- You will be expected to pay your share of cost at check in.
  - This will include any office services including drugs

- Are we contracted with your insurance company?
  - YES – You will be required to pay your co-payment and/or deductible at check in.
  - NO – You will be required to pay in full at check in.

- Do you have a SECONDARY INSURANCE?
  - YES – You will be required to pay your co-payment and co-insurance amounts at check in. We will bill your secondary insurance; if we receive payment we will reimburse you any excess amounts.

- You may receive charges from an outside laboratory. These charges were incurred because the tests were necessary to diagnose and/or treat your condition.

- We will bill your insurance(s) as a courtesy. Payments received in excess of your account balance will be refunded to you.

HMO, EPO, POS OR MANAGED CARE PLANS

- Has your primary care physician AUTHORIZED your visit?
  - Visits with prior approval. If your plan requires a co-payment, you will be required to pay at check in.
  - Visits without prior approval. You will be required to pay in full at check in.

You will be required to PAY IN FULL at check in if;

- You are **OUT OF NETWORK**
- You have **NO INSURANCE**
- We are **NOT CONTRACTED WITH YOUR INSURANCE**

We recommend that you verify your benefits with your insurance plan prior to your visit.

IF YOU FAIL TO PROVIDE COMPLETE, UP-TO-DATE, ACCURATE INSURANCE INFORMATION

- You will be considered a **CASH** patient and will be **required to pay in full** at check in.
- OCUA will not be responsible for billing insurance for this date of service retroactively

Effective May 1, 2009 the Federal Trade Commission (FTC) has implemented a new regulation known as the Red Flag Rule requiring physicians to develop and implement identity theft detection and prevention programs. **TO PROTECT YOU AGAINST IDENTITY THEFT** we are required to ask for a photo ID, and a second type of identification.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY FOR ORANGE COUNTY UROLOGY ASSOCIATES, INC.

_____	_____	_____
Print Name	Signature	Date

Point of Service Option

We understand you have the ability to use a Point of Service (**POS**) or HMO option. Orange County Urology Associates, Inc. holds contracts with several HMO groups. If we hold a contract it is best for you to take advantage of your HMO option, this will decrease your out of pocket expense.

If you choose to use your POS option Orange County Urology Associates, Inc. will collect your entire out of pocket expenses.

Please be aware if you choose the POS option your plan may not allow you to switch over to the HMO option for your future care.

_____ _____

Print Name Sign Name

_____ _____

OCUA Signature Date

****

ORANGE COUNTY UROLOGY ASSOCIATES, INC.
A Medical Group

25200 La Paz Road, Suite 200
Laguna Hills, CA. 92653
ph (949) 855-1101 fax 855-8710

You have been referred to the Male Infertility Centre at Orange County Urology Associates. We provide highly specialized care for men with infertility.

As a part of our efforts to provide the best care possible for couples with infertility, we are trying to understand more about the causes of infertility, so that we can better treat couples with infertility. We are involved with a research study with 30 other centers in North America to gather more information about couples with infertility. This information will be used to understand more about the causes and treatments of infertility.

If you agree to participate in this important study on infertility, simply fill in the attached sheet with information on your personal history and previous treatments, and hand the completed sheet to our staff with your other paperwork. The information you enter will remain confidential at all times. Your information will be kept without any personal identifiers so it will not be possible to withdraw your information from the study once it is submitted. If you decide to not participate in this study, your care at our center will not be affected.

ARC Fertility History Form

ARC Centre: 0 1 1 | Centre Record Number: | Zip Code / Postal Code: | Height: ft Inches | Weight: lbs

Race:

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ White
☐ Black or African American ☐ Other Race

Ethnic background:

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Your birth year: | Partner birth year: | No Partner ☐

Fertility History

Who referred you to this Male Infertility Clinic?
○ Self referred ○ Gynecologist/reproductive endocrinologist/woman's fertility specialist
○ Primary care physician/family doctor ○ Other (please specify) _____

Pregnancy with *current* partner: ☐ Yes ☐ No
If *Yes*, did pregnancy result in a child: ☐ Yes ☐ No If *Yes*, children's ages: Child 1 | Child 2 | Child 3 | Child 4

With your *current* partner:
How long have you had unprotected sex not resulting in pregnancy? Years / Months
On average, how often do you have vaginal sex each week? / week

Pregnancy with *previous* partner: ☐ Yes ☐ No
If *Yes*, did pregnancy result in a child: ☐ Yes ☐ No If *Yes*, children's ages: Child 1 | Child 2 | Child 3 | Child 4
Have you had a vasectomy? ☐ Yes ☐ No If yes, in what year?

Previous Infertility Testing & Treatment

Has your wife/partner had a fertility evaluation? ☐ Yes ☐ No
Does she have a fertility problem? ☐ Yes ☐ Unknown ☐ No

Have you had sperm testing (Semen Analysis)? ☐ Yes ☐ No
Was the test abnormal? ☐ Yes ☐ Unknown ☐ No

Have you had a fertility investigation by a **male fertility specialist**? ☐ Yes ☐ No
IUI (artificial insemination)/Sperm Wash ☐ Yes ☐ No
IVF (in vitro fertilization)/ICSI intracytoplasmic sperm injection) ☐ Yes ☐ No

Lifestyle

Current tobacco use.... ☐ Yes ☐ No If yes: ○ <1 ○ 1 ○ 2 ○ >2 pack(s) per day How many years?
Alcohol..... ☐ Yes ☐ No If yes: ○ <1 ○ 1 ○ 2 ○ 3 ○ ≥4 drink(s) per day
Marijuana.....Used in last six months? ☐ Yes ☐ No If yes: ○ Daily ○ Few times/week ○ Weekly ○ Monthly or less
Cocaine.....Used in last six months? ☐ Yes ☐ No
Other drugs...Used in last six months? ☐ Yes ☐ No Type _____

Are you presently taking or have you taken within the last 6 months

Finasteride (propecia) or dutasteride?..... ☐ Yes ☐ No
Testosterone or anabolic steroids?..... ☐ Yes ☐ No
Was the testosterone prescribed by a doctor? ☐ Yes ☐ No If yes, what type of doctor? ☐ Family Dr ☐ Urologist ☐ Endocrinologist ☐ other doctor

Why are you using testosterone?
☐ Athletics ☐ Low energy
☐ Increase strength ☐ Low testosterone
☐ Treat infertility ☐ Other (please specify): _____
☐ Low sex drive ☐ Unknown

For clinic use only
Fertility Diagnosis (check all that apply)
☐ NOA ☐ OA ☐ Oligospermia ☐ Asthenospermia ☐ Oligoasthenospermia ☐ Low ejaculate volume ☐ Anejaculation ☐ Varicocele

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ORANGE COUNTY UROLOGY ASSOCIATES, INC
A Medical Group

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Orange County Urology Associates, Inc.
Media Consent Form

Orange County Urology Associates is committed to educating the public and other healthcare providers about medical treatments and innovations. One of the most effective ways to share health and medical news is through personalized patient stories. Thank you for agreeing to participate in these educational efforts. This form ensures that you understand how your information will be used and that you agree to its release.

The information includes:

Patient testimonials (text, audio, video)

I understand that any written testimonial, photograph, movie, video or audiotape taken will become and remain the sole property of Orange County Urology Associates. I agree that the interview, negatives, prints, videotapes, audiotapes or computer graphics may be used for any purpose, including brochures, magazines, email campaigns, Web sites (including Twitter, Facebook and YouTube), individual OCUA physician Web sites, billboards, advertisements, exhibits, audiovisual or multimedia presentations, kiosk imaging, news stories and broadcasts (including their websites), and any other news, public service, promotional or advertisement reason.

I understand that news media organizations are not covered by federal privacy regulations and, once released, may become available for use by the media at any time in the future.

Patient Name	Signature	Phone	Date
Spouse Name	Signature	Phone	Date
Street Address			
City	State		Postal/ZIP Code
Patient Email	Spouse Email		
Parent/Guardian Name (Minors Only) (Please Print)	Signature		Date
Practice Administrator, Orange County Urology Associates, Inc. (Please Print)	Signature		Date

Please mail your signed copy to: Orange County Urology Associates, Attn: Christie Leach, 25200 La Paz Road, Laguna Hills, CA 92653. We will then send you a duplicate of the signed final copy. Thank you again for your participation in these patient education activities.

This authorization will not expire.