JILL BYERS M.D.
Southern California Continence Center

Name: Last_____ First:_____Middle:_____

Gender: ☐ Male ☐ Female ☐ Decline to state/other

Date of Birth _____Social Security Number (optional)_____

Home Address: _____

City _____ State _____ Zip Code _____

Email address: _____
Mobile/cell phone number _____ Home phone number_____
(Do you authorize us to leave messages at the above numbers) _____*Yes*_____*No*
Emergency contact:_____Phone number_____
Relationship to you:_____

Census bureau required questions:
Race: *please circle one*
Decline to state White
Black or African American
American Indian Alaska Native
Native Hawaiian Filipino Chinese
Japanese Korean Asian Guamanian
Samoan Tongan Vietnamese
Other:_____
Ethnicity: *please circle one*
Decline to state Hispanic/Latino
Not Hispanic/Latino Unknown
Other:_____
Language preference: *please circle one*
English Spanish Mandarin
Farsi French German Italian
Russian Other_____

Primary Insurance Company:

Name _____

Policy # _____

Group # _____

Secondary Insurance Company:

Name _____

Policy # _____

Group # _____

PHARMACY NAME _____
PHARMACY PHONE _____
PHARMACY ADDRESS _____

I request that payment of authorized Insurance benefits be made either to me or on my behalf to Southern California Continence Center for any services furnished to me by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. By signing below, I acknowledge my share of costs and agree to be responsible for paying the amount due.

Signature _____ Date _____

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Patient Urological Questionnaire

Name: Last _____ First_____Middle_____
Date of Birth_____ Age_____Height_____Weight _____
Referring Physician _____Primary care physician_____

Reason for today's visit

_____
_____
_____

Have you had any recent imaging (Ultrasound, CT or MRI) of the abdomen (kidneys)?

☐ YES ☐ NO If Yes, where was the imaging done?_____

List ALL Medications you are currently taking, including aspirin and other non-prescription medications (no need to list vitamins and supplements) - *or attach medication list*

_____
_____
_____

Circle any of the following urologic medications you have taken in the past and are no longer taking

Ditropan/oxybutynin Detrol/tolterodine Vesicare/solifenacin Enablex/darifenacin
Sanctura/trospium Myrbetriq Gemtesa Hytrin (terazosin)
Flomax (tamsulosin) Uroxatral (alfuzosin) Proscar (finasteride) Avodart (dutasteride)

List **ALL Allergies** including to Medications, Latex, Tape, etc and type of reaction:

_____
_____

Have you ever smoked cigarettes? ___Yes ___No For how long? _____years
How many day?____packs. Are you still smoking? ___Yes ___No, I quit in _____ (year)
Have you ever used recreational drugs? _____Yes _____No___ which one(s)_____
Are you still using them?_____Yes____No, I quit in _____(year)
Alcohol Use ____Yes ____No_____ How many drinks a day _____ or week _____

Do you have any family history of and if so how are you related? (eg breast cancer - my mother)
Kidney Stones_____ Breast Cancer _____ Prostate Cancer_____

Is there anything else you want us to know about you today?

_____
_____
_____

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Current or recent symptoms: *please circle all that apply*

Chest pain Dizziness Trouble breathing Coughing Fever Chills Nausea Vomiting Diarrhea
Blood in the urine Frequent urination Incontinence of urine Slow urine stream Incomplete voiding
Other symptoms you have recently or are currently experiencing:

Past Medical History: *please circle all that apply*

Cardiovascular: Atrial Fibrillation
Congestive Heart Failure MI/Heart Attack
High Cholesterol High Blood Pressure
Heart Surgery Type: Bypass Valve Repair
Pacemaker
Other: _____

Hematologic: Anemia *Bleeding Tendency*
Blood transfusions *Easy bruising*

Respiratory: Asthma *COPD/Emphysema*
Pulmonary fibrosis *chronic cough*
Sleep apnea CPAP
Other:_____

Psychological: Anxiety *Depression*
Bipolar disorder
Other:_____

Musculoskeletal: Arthritis *Rheumatoid Arthritis*
Back Surgery *Spinal Stenosis* Fibromyalgia
GOUT Osteoporosis Osteopenia
Joint Replacements:
Hip: Side: _____year_____

Knee: Side: ____year_____

Endocrine: Breast Cancer when:_____
Diabetes *Hyper / Hypothyroidism*
Low Testosterone *Weight Loss*

GI: GERD (Heartburn/Reflux) *Colon Cancer*
IBS Type: Constipation / Diarrhea
Fecal incontinence
Appendectomy Cholecystectomy

Eyes & Ears: Hearing Loss *Cataract removal*
Glaucoma *Macular degeneration*

Obstetric/ (Uro) Gyn:
Vaginal Deliveries How many _____
C-Sections *How many* _____
Hysterectomy_____why?_____
Bladder "lift" or Sling_____
Are you or could you possibly be pregnant?
Yes_____ No_____
Last Menstrual Cycle:_____

Urological: Kidney Stones *Prostate Cancer*
Bladder Cancer Urinary tract infections
Urinary incontinence

Neurological: Neuropathy *Parkinson's Disease*
Multiple Sclerosis *Migraines* Tremors *Vertigo*
Memory Impairment *Stroke / TIA* Seizures
Neuropathy

Other: (Please list any medical conditions or surgery you have had that is not listed above
_____
_____
_____
_____

None of the above: (Please Initial) _____

Today's Date _____

Name _____

Birthdate _____

Doctor _____

Your IPSS Score

The International Prostate Symptom Score[1] (IPSS) is used to assess the severity of BPH symptoms. To calculate your score, rate your symptoms based on your experience during the last month.

During the last month how often have you...	NOT AT ALL	LESS THAN 1 IN 5 TIMES	LESS THAN HALF THE TIME	ABOUT HALF THE TIME	MORE THAN HALF THE TIME	ALMOST ALWAYS	SCORE
1. Had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5	
2. Had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
3. Found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Found it difficult to postpone urination?	0	1	2	3	4	5	
5. Had a weak urinary stream?	0	1	2	3	4	5	
6. Had to push or strain to begin urination?	0	1	2	3	4	5	

	NONE	1 TIME	2 TIMES	3 TIMES	4 TIMES	5+ TIMES	SCORE
7. During the last month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5	
						TOTAL SYMPTOM SCORE	

Quality of life due to urinary symptoms	DELIGHTED	PLEASED	MOSTLY SATISFIED	MIXED	MOSTLY DISSATISFIED	UNHAPPY	TERRIBLE
8. If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

The total possible score ranges from 0 to 35 with the following BPH symptom correlation:
0-7 Mild symptoms, 8-19 Moderate symptoms, 20-35 Severe symptoms

BPH Medication Satisfaction Survey

Current BPH medication: _____

How long have you been on BPH medications?

☐ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ 1 year or more

Since starting your BPH Medication have you experienced any of the following side effects? (Check all that apply)

	Symptom	New or Continuing?
☐	Intermittent urination (starting & stopping)	☐ New since starting BPH meds ☐ Continuing since starting BPH meds
☐	Poor stream during urination	☐ New since starting BPH meds ☐ Continuing since starting BPH meds
☐	Unable to completely empty your bladder (feels like there is more even after going to the bathroom)	☐ New since starting BPH meds ☐ Continuing since starting BPH meds
☐	Painful urination	☐ New since starting BPH meds ☐ Continuing since starting BPH meds
☐	Need for frequent urination: day, night or both	☐ New since starting BPH meds ☐ Continuing since starting BPH meds
☐	Sudden or strong urge to urinate	☐ New since starting BPH meds ☐ Continuing since starting BPH meds
☐	Leakage – urine with little or no warning (sometimes unable to make it to the bathroom in time)	☐ New since starting BPH meds ☐ Continuing since starting BPH meds
☐	Nausea	☐ New since starting BPH meds ☐ Continuing since starting BPH meds
☐	Headaches	☐ New since starting BPH meds ☐ Continuing since starting BPH meds
☐	Dizziness	☐ New since starting BPH meds ☐ Continuing since starting BPH meds
☐	Decrease or stoppage in ejaculatory fluid	☐ New since starting BPH meds ☐ Continuing since starting BPH meds

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided you? Circle a number.

0 1 2 3 4 5 6 7 8 9 10

No relief — Complete relief

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your BPH symptoms? Circle a number.

0 1 2 3 4 5 6 7 8 9 10

No frustration — Extreme frustration

Are you interested in learning about a new therapy to treat your BPH?

☐ Yes ☐ No

Would you like your doctor to make a recommendation?

☐ Yes ☐ No

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ASSIGNMENT OF BENEFITS:

I assign all insurance benefits to Southern California Continence Center. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Dr. Byers' office is not responsible for knowing my plan, what it will pay for, or the deductible requirements. I also understand that it is my responsibility to ensure that any prior authorizations required by my plan or medical group have been approved prior to treatment or services. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I hereby give my consent for examination, treatment and insurance billing.

Signature _____ Date _____

Print Name _____

Identity Theft Prevention

Patients are required to present photographic identification or some other form of proof of identity in addition to their insurance eligibility and. A copy of this information will be retained in the patient's protected record so as to efficiently verify each established patient's identity on return visits. We may also ask to take a digital photo of the patient to keep with their electronic medical record to further safeguard identity.

Acknowledgement of Receipt of Notice of Privacy Practices:

Attestation
By Initialling and dating below, I acknowledge that I have been given access to the Southern California Continence Centers Corporate Privacy Notice (located at www.byersuro.com)

Signature of Patient or Patient's Representative

Signature _____ Date _____

Print Name
_____

_____ **Initial Here** to consent to receive personally identifiable mailings from us

_____ **Initial Here** to consent to receive personally identifiable phone calls and voicemails from us (appointment reminders, follow ups, etc)

_____ **Initial Here** to consent to receive E-mail correspondence from us with personally identifiable information (lab results, reminders, follow-ups, notifications, advice, etc)

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"No Show" and "Cancellation" Policy

Our practice is dedicated to providing quality urological care in a timely manner. The physician and her staff spend a considerable amount of time preparing for your appointment. If you find you must change your appointment, we ask that you do so with at least 48 hours notice. Giving us notice will allow us time to reallocate the appointment to another patient and reduce delays in patient care. Cancellations caused by insurance authorization denials or by the office or facility will not incur a fee.

➤ Patients who fail to keep their scheduled appointments without notifying the office within 48 hours of their scheduled appointment time, shall be subject to an administrative fee of **$25.00.** In the event prior notice cannot be given because of an actual emergency, consideration will be given and a one-time exception may be granted.

➤ Patients who fail to keep a scheduled office procedure appointment and who have not notified the office within 48 hours of the scheduled appointment time shall be subject to an administrative fee of **$100.00.**

➤ Patients who fail to keep a scheduled surgery appointment and who have not notified the office within 48 hours of the scheduled surgery date, shall be subject to an administrative fee of **$300.00.**

HOW TO CANCEL YOUR APPOINTMENT

To cancel or reschedule appointments, you may call our clinic at (949) 515-3777 and leave a voicemail with your name, appointment date and cancellation reason or request for rescheduling. You may also email us directly at appointments@byersuro.com.

***Our office makes every effort to remind patients of upcoming appointments, however, it is ultimately each patient's responsibility to keep appointments they have scheduled. Administrative fees are not covered by insurance and therefore are the sole responsibility of the patient. ***

Patient name:_____

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date