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_____
(Please initial if you authorize us to leave messages at the above numbers) _____
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?

_____
_____
_____

Southern California Continence Center/Dr Jill Byers

Name Date

PELVIC PAIN and URGENCY/FREQUENCY PATIENT SYMPTOM SCALE

Please circle the answer that best describes how you feel for each question.

		0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1	How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2	a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
	b. If you get up at night to go to the bathroom, does it bother you?	Never Bothers	Occasionally	Usually	Always			
3	a. Do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
	b. Has pain or urgency ever made you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
4	Do you have pain associated with your bladder or in your pelvis (vagina, labia, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
5	a. If you have pain, is it usually		Mild	Moderate	Severe			
	b. Does your pain bother you?	Never	Occasionally	Usually	Always			
6	Do you still have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7	a. If you have urgency, is it usually		Mild	Moderate	Severe			
	b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
8	Are you sexually active? Yes___ No___							

SYMPTOM SCORE = (1, 2a, 3a, 4, 5a, 6, 7a)	
BOTHER SCORE = (2b, 3b, 5b, 7b)	
TOTAL SCORE (Symptom Score + Bother Score) =	

Total score ranges from 1 to 35.

A total score of 10-14 = 74% likelihood of positive PST; 15-19 = 76%; 20 or above = 91% likelihood of positive PST.

Revised 11/17/2003

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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) _____

Appointment "No Show" and "Cancellation" Policy

Our practice is dedicated to providing quality care in a timely manner. Late cancellations and unkept appointments cause delays in patient care, not only for the patient not keeping the appointment, but also for the patient who could have been seen at the scheduled time. We understand that many of our patients are juggling busy schedules and multiple appointments. If you find you must change your appointment, we ask that you do so with at least 48 hours notice. Giving us notice will enable us to offer the appointment time to another patient.

To discourage late cancellations and missed appointments we have instituted the following policy:

➢ Failure to keep a scheduled appointment without notifying the office at least 48 hours prior to the scheduled appointment time will result in an administrative fee of **$40.00.**

➢ Failure to keep a scheduled office procedure appointment without notifying the office at least 48 hours prior to the scheduled appointment time will result in an administrative fee of **$100.00.**

➢ Failure to keep a scheduled surgery appointment without notifying the office at least 48 hours prior to the scheduled surgery time will result in an administrative fee of **$300.00.**

HOW TO CANCEL AN APPOINTMENT

To cancel or reschedule appointments, you may call the office 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 an 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 are the responsibility of the patient.

By signing below, you indicate that you understand and agree to the above policy.

Patient name:_____

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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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)

JILL BYERS M.D.
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Jill Byers , M.D.
320 Superior Ave. #110
Newport Beach, CA 92663
Phone: 949- 515- 3777
Fax: 949-480-3404

I hereby authorize and request the release of copies of the following information:

Doctors Notes ( ) Laboratory Results ( ) Imaging Reports ( ) Pathology Reports ( )

Others ( )

From: _____
_____
_____

To: _____
_____
_____

This information has been released to you specifically with the consent of the patient or his/her Authorized representative. It is strictly confidential and no further release of the information is authorized without the consent of the patient or authorized representative. I hereby release the facility from any liability, which may arise as a result of the use of this information in the records released.

Patient Name:_____ **Date of Birth:**_____

Signature: _____ **Date:**_____