Golden Gate Urology, Inc.
Q. Robert Yan M.D.

Patient Registration Information

Name: _____ _____ _____
(last) (first) (middle)

Date of Birth: ___/___/___ Sex: Male / Female **SSN:** _____
mm dd yy

Address: _____ **City:** _____ **Zip:** _____

EMAIL: _____ **PHARMACY:** _____
(ADDRESS)

Marital Status: Married Single Widowed Divorced **Race:** Asian African-American Hispanic Caucasian
(CIRCLE ONE) (CIRCLE ONE)

Principal spoken language: English Cantonese Mandarin Spanish Vietnamese Other: _____
(CIRCLE ONE)

Referred by Dr. _____ Driver's lic. # _____

Are you currently residing in a Skilled Nursing Facility? Yes / No
If yes, Name of facility: _____ Telephone # _____

Contact Information:
(home phone) _____ (cell phone) _____
☐ O.K. to leave message with detailed information ☐ Leave message with call-back number only

Employer: _____ (work phone) _____
☐ O.K. to leave message with employer or on voice mail ☐ Leave message with call-back number only

Spouse's name: _____ SSN: _____

Emergency contact: _____ Relationship: _____ (Phone): _____
☐ O.K. to leave message with detailed information ☐ Leave message with call-back number only

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Responsible Party (complete only if patient is not responsible party):

Name: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Telephone: (home) _____ (cell/work): _____

Assignment of Benefits / Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Golden Gate Urology, Inc., and any assisting physicians for services rendered.
I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Signed: _____ Date: _____

We have a notice of privacy practices for confidentiality policies available for review.

Financial Policies of and Agreement with Golden Gate Urology, Inc.

We would like to provide you with the best service possible for your urologic care. In order to avoid any confusion or misunderstanding, we would like to clarify our financial policies with you.

Your Insurance: Please submit current insurance information during your visit with the doctor. We will bill your insurance company for all the services that we provide which are covered under your insurance policy. **Services not covered by your insurance must be paid for at the time of service.**
We will make our best effort at estimating your share of the office visit or procedure. However, until your insurance company has processed our claim, we will not know for sure how much you may have to pay. You may choose to contact your own insurance carrier to inquire about the estimated cost. We do request for payment of the estimated amount at the time of your visit – any overpayments will be promptly refunded upon receipt of a finalized, processed claim from your insurance. Any balance due will be billed to you and payable within 30 days.
It is your responsibility to verify with your insurance carrier if we are a participating provider for your particular insurance plan. You are financially responsible for all medical services rendered to you regardless of the decision involving reimbursement by your insurance carrier. Since Dr. Robert Yan provides urologic service(s) directly to you, and not to your insurance company, you are ultimately responsible for all fees incurred.
Co-payments and deductible amounts must be paid for before you see the doctor. There will be a $10 billing fee for co-payments/deductibles not paid at the time of your visit.

Medicare Patients: Medicare pays 80% of the allowable charges after your annual deductible is met. If you do not have a secondary insurance, you are responsible for the remaining 20% and any deductible amount.

Patients with No Insurance: We request that you pay at the time of service.

A general fee guideline for filling out forms is as follows:

Medication pre-authorization	$20	Each misc. form (depending on complexity)	$20 - $40
Insurance appeal for non-coverage of medication	$50	Employer/State Disability	$20

There may be instances where the paperwork you wish us to fill out is more extensive than usual. In those cases, we will let you know in advance if additional charges are due. Payment is due with your request. Please allow 5 business days for us to prepare all forms. We will call you when the form is ready for pick-up.

Medical records: There will be a $20 fee for the preparation and release of medical records. Please allow at least 1 week for the preparation of medical records. Additional copying charges may be assessed.

Accepted Forms of Payment: Cash and personal checks are acceptable forms of payment. There will be a $40 charge for returned checks.

Cancellation Policy: We require advance notice for any cancellations or re-scheduling:
Office appointment – at least 24 hours notice Surgery in the Hospital or Surgery Center – 1 weeks' notice
The following cancellation fees will be assessed if we do not receive your cancellation or re-scheduling notice in time:
Office follow-up appointment - $50 Office procedure - $100 Surgery - $200
Your insurance companies will NOT pay for these charges - they are solely your responsibility. Please notify us of any changes in your address and/or telephone numbers so that we can provide reminders for your appointments.

Collection Policy: All payments are due within 30 days of billing. Thereafter, monthly finance charges of 1% (12% per annum) will be assessed (minimum $5) along with a $10 re-billing fee for each statement generated. If your account is 60 days past due, immediate payment in full is advised to avoid collection proceedings. In the event of default, any and all collection fees will be your responsibility. If you need to discuss alternative payment arrangements, please call our office and arrange to speak with our Office Manager.

Your signature below will acknowledge your understanding of and agreement to these terms, and that a copy can be made for your reference.

_____
Name (please print)

_____ _____
Signature Date

Patient Name:_____ DOB:_____
Last First MI MM/DD/YYYY

Today's Date:_____
MM/DD/YYYY

Review of systems

Do you have any of the following problems? Please circle Yes (Y) or No (N).

General	CIRCLE!	
Fevers	Y	N
Chills	Y	N
Sweats	Y	N
Fatigue	Y	N
Malaise	Y	N
Weight Loss	Y	N

Eyes:		
Blurring	Y	N
Discharge	Y	N
Vision Loss	Y	N
Eye Pain	Y	N
Light Sensitivity	Y	N

Cardiovascular:		
Chest Pain	Y	N
Palpitations	Y	N
Fainting Spells	Y	N
Sleep on 2 or more pillows	Y	N
Swelling in legs	Y	N

Respiratory:		
Cough	Y	N
Shortness of Breath	Y	N
Excessive Sputum	Y	N
Bloody sputum	Y	N
Wheezing	Y	N

Gastrointestinal:		
Nausea	Y	N
Vomitting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Change in Bowel Habits	Y	N
Abdominal Pain	Y	N
Bloody stools	Y	N

Other:

Musculoskeletal:	CIRCLE!	
Back Pain	Y	N
Joint Pain	Y	N
Joint Swelling	Y	N
Muscle Cramps	Y	N
Muscle Weakness	Y	N
Arthritis	Y	N

Skin:		
Rash	Y	N
Itching	Y	N
Dryness	Y	N
Suspicious Changes	Y	N

Neurologic:		
Loss of use in limbs	Y	N
Weakness	Y	N
Numbness	Y	N
Seizures	Y	N
Tremors	Y	N
Vertigo	Y	N

Endocrine:		
Cold Intolerance	Y	N
Heat Intolerance	Y	N
Frequent eating	Y	N
Frequent drinking	Y	N
Frequent urination	Y	N

Heme/Lymphatic		
Abnormal Bruising	Y	N
Bleeds Easily	Y	N
Enlarged Lymph Nodes	Y	N

Family History:

Mother: Living/Deceased Age of death: ___ Cause of death: _____

Father: Living/Deceased Age of death: ___ Cause of death: _____

Brothers:

# of brothers: ___ # Living: ___ # deceased: ___ Cause of death: _____

Sisters:

# of sisters: ___ # Living: ___ # deceased: ___ Cause of death: _____

Social history:

Occupation: _____

Marital status: Married / Single / Widowed / Divorced

Smoker? Current/previous/never Packs a day: ___ Years: ___ Yr quit: ___

Alcohol use: Yes/No

Drinks per day: ___ Type:_____ (i.e. Beer, Wine, Mixed Drinks) Frequency:_____ (i.e. Daily, Weekly, Monthly, Yearly)

Vital signs:

Height(in):_____

Weight (pounds): Pulse Rate: ____ BPM Respirations/Min:_____

Comments:

Chief complaint:

Medications:

Allergies:

Patient name: _____ DOB: _____
LAST FIRST MI (生日)

Review of systems

Do you have any of the following problems? Please circle Yes (Y) or No (N).
你现在有下列的毛病吗？请圈"有"或"無"

	圈 (Y/N)!!! 有	無
General: (全面的)		
Fevers(发烧)	Y	N
Chills (发寒)	Y	N
Sweats (出冷汗)	Y	N
Fatigue (疲劳)	Y	N
Malaise (不安/身体无力)	Y	N
Weight Loss (体重降低)	Y	N
Eyes: (眼睛)		
Blurring (模糊)	Y	N
Discharge(不正常液体排出)	Y	N
Vision Loss (视力丧失)	Y	N
Eye Pain (眼痛)	Y	N
Light Sensitivity (对光敏感)	Y	N
Cardiovascular: (心脏血管的)		
Chest Pain (胸膛痛)	Y	N
Palpitations (心跳加速)	Y	N
Fainting Spells (不省人事)	Y	N
Sleep on 2 or more pillows (使用2个或以上的枕头睡觉)	Y	N
Swelling in legs (脚肿)	Y	N
Respiratory: (呼吸系统)		
Cough (咳嗽)	Y	N
Shortness of Breath (呼吸短促)	Y	N
Excessive Sputum (多痰)	Y	N
Bloody sputum (血痰)	Y	N
Wheezing (喘息声)	Y	N
Gastrointestinal: (肠胃的)		
Nausea (反胃)	Y	N
Vomiting (呕吐)	Y	N
Diarrhea (腹泻)	Y	N
Constipation (便秘)	Y	N
Change in Bowel Habits (大便的习惯改变)	Y	N
Abdominal Pain (腹痛)	Y	N
Bloody stools (血便)	Y	N
Other: (其他的)		

	圈 (Y/N)!!! 有	無
Musculoskeletal: (肌肉与骨骼)		
Back Pain (背痛)	Y	N
Joint Pain (关节痛)	Y	N
Joint Swelling(关节肿)	Y	N
Muscle Cramps (肌肉抽筋)	Y	N
Muscle Weakness (肌肉无力)	Y	N
Arthritis (关节炎)	Y	N
Skin: (皮肤)		
Rash(红疹)	Y	N
Itching (痒)	Y	N
Dryness (干燥)	Y	N
Suspicious Changes (怀疑有异常的改变)	Y	N
Neurologic: (神经系统)		
Loss of use in limbs (四肢失控)	Y	N
Weakness (无力)	Y	N
Numbness (麻痹)	Y	N
Seizures (癫痫症)	Y	N
Tremors (颤抖)	Y	N
Vertigo (眩晕， 晕头转向)	Y	N
Endocrine: (内分泌)		
Cold Intolerance (不耐寒的)	Y	N
Hot Intolerance (不耐热的)	Y	N
Frequent eating (进食频繁)	Y	N
Frequent drinking (喝水频繁)	Y	N
Frequent urination (小便频繁)	Y	N
Heme/Lymphatic (血液/淋巴)		
Abnormal Bruising (异常的瘀伤)	Y	N
Bleeds Easily (容易流血)	Y	N
Enlarged Lymph Nodes (淋巴结肿大)	Y	N

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# of brothers: ___ # Living: ___ # deceased: ___ Cause of death: _____

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Comments:

Chief complaint:

Medications:

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