Welcome!

Thank you for choosing Westside Urology. We look forward to your visit with us soon.

Enclosed are the forms we need you to bring with you, completely filled out, to your first visit with us. Some forms are for your information only. Others you will need to fill out and bring with you.

If for some reason you misplace your forms you can call our office and we will send you another copy through the mail, by fax, or email. You also have the option to come to your appointment twenty minutes early to fill these forms out.

If you have any questions about the forms please feel free to give us a call and we will be happy to help you out.

We pride ourselves on providing compassionate, individualized and state-of-the-art urological care for our patients. We have continued to define the standard of care in our community in areas such as cancer treatments, stone disease, incontinence therapies, benign prostatic enlargement and erectile dysfunction. However, we cannot support the ever-decreasing reimbursement from virtually every managed care plan such as "Preferred Provider Organizations" or PPO's. As of June 2001, we have ended our participation in all of those networks which promise physicians increased patient volume in exchange for discounted fees.

We have implemented a reasonable and fair fee schedule. This fee schedule is available for your review before services are provided and our fees are based upon the "Evaluation and Management" principles recognized by the Health Care and Financing Administration of the U.S. Federal Government.

Again, thank you for choosing Westside Urology to assist you with your medical needs and we are excited to meet you!

New Patient Questionnaire

Last ______________________________ First _____________________________ M.I. _____ Date _____________________

Who referred you to our office? ☐ Physician/friend ____ or ☐ Internet

Chief Complaint

What is the Medical Problem leading to today's visit?

History of Present Illness or Condition

Where on your body is the problem?

____

How would you describe the condition?

____

How would you describe the severity of your condition?

____

How long has this condition existed?

____

Is your condition constant or only present during certain situations?

____

How does this condition affect your normal activities?

____

What makes your condition worse or better?

____

Are any other conditions associated with your main condition?

____

Have you been treated for this condition?

☐ No ☐ Yes, treatments ___________________________

____

Review of Systems (circle)

Constitutional
Fever
Chills
Weight Loss
Weight Gain
Weakness
Fatigue

Eyes
Blurred Vision
Double Vision
Eye Pain
Blindness
Colorblindness
Glasses

Ears/Nose/Throat
Deafness
Nasal Congestion
Sore Throat
Hoarseness
Difficulty Swallowing

Cardiovascular
Chest Pain
Heart Palpitations
Abnormal Heart Rhythm
Swelling of ankles

Gastrointestinal
Constipation
Diarrhea
Abdominal Pain
Nausea
Vomiting

Respiratory
Shortness of Breath
Wheezing
Blood in Sputum
Chronic Cough

Musculoskeletal
Arthritis
Decrease Muscle Tone
Bone Pain
Broken Bones

Skin and Breast
Rashes
Moles
Blisters
Breast Tenderness or Lumps
Nipple discharge

Neurological
Dizziness
Weakness of arms or legs
Loss of Sensation of hands, feet

Psychiatric
Depression
Anxiety
Insomnia
Panic Attacks
Thought Disorders

Endocrine
Excessive Thirst
Excessive Urination
Heat or Cold Tolerance

Blood/Lymph System
Bleeding
Bruising
Swollen Lymph Glands

Allergy/Immune
Itchiness
Runny Nose
Rhinitis
Infections

Female Urologic System Review

DR. PETER LOISIDES

Kidney Disorders (circle)
Kidney Stones
Kidney Infection
Renal Failure
Flank Pain
Kidney Obstruction

Bladder Problems (circle)
Cystitis
UTI's
Blood in Urine
Pelvic Pain
Urinary Urgency
Frequency of urination
Burning with urination
Retention of Urine
Inability to empty bladder
Double voiding
Waking to urinate at night
Interrupted stream

Urinary Incontinence (leakage):
☐ with cough, laugh, straining
☐ because of inability to postpone urination
☐ leakage without awareness
☐ need to wear pads for protection from urine leakage

Obstetrical History

Total number of prior pregnancies ______

________	________	________	________
Live Births	Vaginal Deliveries	C-Sections	Terminations/ Miscarriages

Menstrual History (circle)
Normal Periods
Irregular Periods
Peri-Menopausal
Menopausal

Current Birth Control measures, if any

____

Age at Menstruation ______________________

Age at Menopause ______________________

Vaginal/Uterine Problems
☐ Prolapse or bulging sensation in vagina

Vaginal
☐ dryness ☐ itchiness ☐ discharge ☐ bleeding

Sexual History (circle)
Sexually active with normal, satisfying orgasms
Diminished lubrication during sexual stimulation
Difficulty achieving orgasm
Pain with intercourse

Sex drive
☐ Normal ☐ Decreased ☐ No interest

Sexual Orientation
☐ Heterosexual ☐ Homosexual ☐ Bi-sexual

History of Sexually Transmitted Disease?

☐ No ☐ Yes ______________________

Female Past History

DR. PETER LOISIDES

Family History
Please list any Major Hereditary
or Major Illness in your family

____

Cause of death of any immediate family members

Family Member	Cause of Death
______________	______________
______________	______________
______________	______________

Medical History
Major Medical Conditions/Operations/Injuries

____
____
____
____
____
____
____

Social History

Marital Status
☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Domestic Partnership

Smoking History
☐ Never Smoked ☐ Former Smoker ☐ Smoker

☐ History of Alcohol/Drug Abuse or Addiction

Occupation

____

Fitness/Exercise Regimen

____
____

Male Urologic System Review/Past History

DR. PETER LOISIDES

Kidney Disorders (circle)

Kidney Stones
Kidney Infection
Renal Failure
Flank Pain
Kidney Obstruction

Bladder Problems (circle)

Cystitis
UTI's
Blood in Urine
Pelvic Pain
Urinary Urgency
Frequency of urination
Burning with urination
Retention of Urine
Inability to empty bladder
Double voiding
Waking to urinate at night
Interrupted stream

Urinary Incontinence (leakage):
☐ with cough, laugh, straining
☐ because of inability to postpone urination
☐ leakage without awareness
☐ need to wear pads for protection from urine leakage

Family History

Please list any major Hereditary
or Major Illness in your family

____

Cause of death of any immediate family members

Family Member	Cause of Death
______________	______________
______________	______________
______________	______________

Social History

Marital Status
☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Domestic Partnership

Smoking History
☐ Never Smoked ☐ Former Smoker ☐ Smoker

☐ History of Alcohol/Drug Abuse or Addiction

Sexual History (circle)

Sexually active with normal, satisfying erections, orgasm and ejaculation
Diminished lubrication during sexual stimulation
Difficulty achieving/maintining erections during sex
Difficulty acheiving orgasm

Sex drive
☐ Normal ☐ Decreased ☐ No interest

Sexual Orientation
☐ Heterosexual ☐ Homosexual ☐ Bi-sexual

History of Sexually Transmitted Disease?

☐ No ☐ Yes ______________________________

Medical History

Major Medical Conditions/Operations/Injuries

____
____
____
____
____
____
____

Occupation

____

Fitness/Exercise Regimen

____
____

Current Medications

Medication	Dose	Frequency	Prescribing M.D.

Allergies

Drug/Medication	Reaction (Rash, Shortness of Breath, Nausea, etc.)

Form Completed by

☐ Patient ☐ Parent ☐ Guardian ☐ Power Of Attorney ☐ Caregiver

Patient Unable to Complete Due to ☐ Language Barrier ☐ Mental or Health Status

Reviewed by ______________________________ M.D.

Westside Urology 2001 Santa Monica Boulevard, Suite 590w, Santa Monica, California 90404 tel. 310 829-0039 fax. 310 828-1791 www.mdpeter.com

Patient Registration

DR. PETER LOISIDES

Date ____________________

Last ________________ First ________________ M.I. ______

Address ________________ Apt# ________________

City ________________ State _____ Zip ________________

Home Telephone ________________ Work Telephone ________________

Date of Birth ________________ Age _______ Sex ☐ M ☐ F

Social Security # _______ – _____ – ___________ Driver's License # ________________ State _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Spouse/Partner's Name ________________ Daytime Phone ________________

Your Employer ________________ Occupation ________________

Address ________________ Daytime Phone ________________

Responsible Party (if other than yourself) ________________

Resp. Party's Home Phone ________________ Daytime Phone ________________

By whom were you referred? ☐ Physician/friend ________________ ☐ Internet ________________

Telephone ________________ Fax ________________

Names of other Physicians who care for you (please list below)

Name ________________ Phone ________________

Name ________________ Phone ________________

Name ________________ Phone ________________

Name ________________ Phone ________________

Westside Urology 2001 Santa Monica Boulevard, Suite 590w, Santa Monica, California 90404 tel. 310 829-0039 fax. 310 828-1791 www.mdpeter.com

Insurance Information

DR. PETER LOISIDES

ONLY COMPLETE A AND B IF CARDS ARE NOT PRESENTED.

A. Primary Insurance

Company Name ______________________ Telephone ______________

Claims Address ______________________________________

City ______________________ State ________ Zip ____________

Name of Insured ______________________ Date of Birth ______________

Relationship of Patient to Insured ☐ Self ☐ Spouse ☐ Parent ☐ Child

ID # ______________________ Group # ______________________

B. Secondary Insurance

Company Name ______________________ Telephone ______________

Claims Address ______________________________________

City ______________________ State ________ Zip ____________

Name of Insured ______________________ D.O.B. ______________

Relationship of Patient to Insured ☐ Self ☐ Spouse ☐ Parent ☐ Child

ID # ______________________ Group # ______________________

C. Who May We Contact in Case of an Emergency? (someone not living with you)

Name ______________________ Relationship to Patient ______________

Home Telephone ______________________ Daytime Telephone ______________

Address ______________________________________

Please read the following information carefully regarding insurance billing and patient responsibility. Thank you.

I understand that this office is **only** contracted with Medicare, and is out of network for all other insurances.

I understand that I am responsible for payment in full at the time services are rendered, unless other financial arrangements have been made.

I understand that my insurance company will be billed for me as a courtesy. After 30 days from date of service, it is my responsibility to follow up with my insurance company if payment has not been received.

Assignment of Benefits/Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Peter M. Loisides, M.D./Mark J. Kelly, M.D. and any assisting physicians for any services rendered that are unpaid at the time of service. I understand that I am financially responsible for all charges whether or not they are covered by insurance or should my coverage for health plan benefits not be in effect at the time services are rendered. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees. I hereby authorize Peter M. Loisides, M.D./Mark J. Kelly, M.D. 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.

Patient's Signature ____ Date __________________

Responsible Party (if patient is a minor) ____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally is kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose this information. We may use and disclose your medical records only for each of the following purposes:

Treatment means provide, coordinate or manage health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing collection activities and utilization review.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may also create and distribute health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the following rights with respect to your protected health information, which you can exercise by sending a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of the Notice of Privacy Practices and to make the new notice effective for all protected health information. We will post and you may request a written copy of this notice. If you have any questions about this Notice, or wish to exercise your rights, or file a complaint, please direct your inquires to:

Westside Urological Medical Group
Attention: Privacy Officers
2001 Santa Monica Boulevard, Suite 590w
Santa Monica, California 90404

You may contact your Health Plan or the California Department of Managed Care with your concerns as well. You also have the right to directly complain to the Secretary of the United States Department of Health and Human Service. We will not retaliate against you for filing a complaint against us.

Acknowledgement of Receipt

DR. PETER LOISIDES

I hereby acknowledge that I have received a copy of Westside Urological Medical Group's Notice of Privacy Practices.

Signature ____ Date _____________________

Printed name ____

Relationship to the patient _____________________________

Westside Urology 2001 Santa Monica Boulevard, Suite 590w, Santa Monica, California 90404 tel. 310 829-0039 fax. 310 828-1791 www.mdpeter.com

A Message to our Patients about Arbitration

DR. PETER LOISIDES

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you received is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim would be presented. You can still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings. Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with lack of communication. Therefore, if you have any questions about your care, please ask us.

If this information has been mailed or faxed, the original contract should be signed at the time of your appointment. Thank you.

Westside Urology 2001 Santa Monica Boulevard, Suite 590w, Santa Monica, California 90404 tel. 310 829-0039 fax. 310 828-1791 www.mdpeter.com

Pelvic Pain and Urgency/Frequency Symptom Scale

Patient Name ______________________________ Date ______________

Circle One Answer Per Line	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+		
2a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2b. If you get up at night to go to the bathroom, does it bother you?	Never	Occasionally	Usually	Always			
3. Are you currently sexually active? ☐ Yes ☐ No							
4a. If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
4b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5. 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			
6. Do you still have urgency after you go to the bathroom?	Never	Occasionally	Usually	Always			
7a. If you have pain is it usually	Never	Occasionally	Usually	Always			
7b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8a. If you have urgency, is it usually	Never	Occasionally	Usually	Always			
8b. Does you urgency bother you?	Never	Occasionally	Usually	Always			

Symptom Score (1, 2a, 4a, 5, 6, 7a, 8a)

Bother Score (2b, 4b, 7b, 8b)

Total Score (Symptom Score + Bother Score)

Sexual Health Inventory for Men (SHIM)

Patient Name ____ Date ____________________

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 very common medical conditions 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 your 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

Question						
1. How do you rate your confidence that you could		**1** Very Low	**2** Low	**3** Moderate	**4** High	**5** Very High
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	**0** No Sexual Activity	**1** Almost Never or Never	**2** A Few Times (Much Less Than Half the Time)	**3** Sometimes (About Half the Time)	**4** Most Times (Much More Than, Half the Time)	**5** Almost Always or Always
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	**0** Did Not Attempt Intercourse	**1** Almost Never or Never	**2** A Few Times (Much Less Than Half the Time)	**3** Sometimes (About Half the Time)	**4** Most Times (Much More Than, Half the Time)	**5** Almost Always or Always
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	**0** Did Not Attempt Intercourse	**1** Extremely Difficult	**2** Very Difficult	**3** Difficult	**4** Slightly Difficult	**5** Not Difficult
5. When you attempted sexual intercourse, how often was it satisfactory for you?	**0** Did Not Attempt Intercourse	**1** Almost Never or Never	**2** A Few Times (Much Less Than Half the Time)	**3** Sometimes (About Half the Time)	**4** Most Times (Much More Than, Half the Time)	**5** Almost Always or Always

Total Score (Add the numbers corresponding to questions 1–5) ______

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints

1–7	8–11	12–16	17–21
Severe ED	Moderate ED	Mild to Moderate ED	Mid ED

Westside Urology 2001 Santa Monica Boulevard, Suite 590w, Santa Monica, California 90404 tel. 310 829-0039 fax. 310 828-1791 www.mdpeter.com

AUA Symptom Score (AUASS)

DR. PETER LOISIDES

Patient Name ______________________________ Date ______________

Circle One Number Per Line	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
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often had you had to push or strain to begin urination?	0	1	2	3	4	5
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**
Over the past month, how many times per night 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 Score (Add the score for each number above and write the total in the space to the right)

Symptom Score	1–7	8–19	20–35
	Mild	Moderate	Severe

Quality of Life (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Westside Urology 2001 Santa Monica Boulevard, Suite 590w, Santa Monica, California 90404 tel. 310 829-0039 fax. 310 828-1791 www.mdpeter.com