

Dr. Theodore V. Benderev Dr. Kym A. Kanaly Dr. Patricia A. Wallace
26732 Crown Valley Pkwy, Suite 327
Mission Viejo, CA 92691
949.364.4400 Fax: 949.364.2829

Dear Valued Patient:

Thank you for choosing to schedule your appointment with our office for your health care needs. Our commitment to quality and to our patients governs every aspect of our work. We believe in providing technically advanced treatment with personalized attention and welcome you to our Practice.

Enclosed please find the information packet necessary to complete your chart. In order to serve you in a timely manner, we ask that you **complete the information PRIOR** to your appointment scheduled on _____, at _____ and **bring this information back with you** at the time of your appointment. If your paperwork is incomplete or forgotten, you may arrive 30 minutes early to fill out paperwork or we will likely have to reschedule your appointment.

Please bring with you your insurance card and driver's license or photo ID. Deductibles and co-payments are due and will be collected at the time of your visit. You will be responsible for payment at the time of service if you arrive without your insurance card. We are contracted with Medicare and most PPO insurance plans. We are contracted with three HMO's: 1) Memorial Care Medical Group, 2) Mission Hospital Affiliated Physicians and 3) Mission Heritage. We do not verify benefits nor check eligibility prior to your appointment. To avoid insurance or contracting issues, we strongly encourage you to contact your insurance plan and verify your benefits, eligibility and verify that the doctor you are seeing is a contracted provider and is in network prior to seeking treatment. Your insurance is a contract between you and your carrier. Our staff will assist you to the best of their ability in dealing with your insurance company, but it is your responsibility to know and understand your insurance policy and coverage of your plan before you arrive for your visit.

We are located in the Mission Medical Tower. Our office can be reached by turning at Los Altos off of Crown Valley Parkway. Paid parking is available in the covered parking structure and surrounding areas behind our building. Please note we are tenants of Mission Hospital and there is a fee when parking on its campus. As such, we do not validate parking.

Please feel free to call us at (949) 364-4400 and select option 2, if you have any questions or visit our website at www.urology-gynecology.com. Thank you for choosing our office. We look forward to serving you.

Patient Name: _____ **Date:** _____

Female Urinary and Pelvic History

(covering cystitis, urinary leakage, frequency, urgency, burning, pelvic pain, interstitial cystitis, blood in the urine, vaginal bulging, pain with intercourse, loss of stool)

What is your Chief Complaint? (the main reason that brought you in today):

PELVIC HEALTH CONCERNS Please circle and fill out the following:

Have you seen blood in your urine?	Yes	No
Have you been told that you have microscopic blood in your urine (blood not visible by the eye)?	Yes	No
Do you have a strong urge before you urinate?	Yes	No
On average, how often do you urinate?	Every _____ hours	
How many times do you get up at night to urinate?	_____ times	
Do you have a feeling of incomplete bladder emptying?	Yes	No
Do you have a reduced force of urinary stream?	Yes	No
Do you leak urine with activity?	Yes	No
Do you leak urine associated with urgency?	Yes	No
Do you have urethral pain?	Yes	No
Does it burn when you urinate?	Yes	No
Have you had repeated urinary tract infections?	Yes	No
Can you feel something bulging out from the vagina?	Yes	No
Do you have a sense of pressure in the vagina at times?	Yes	No
Do you have to push on your vagina to urinate or to have a bowel movement?	Yes	No
Do you have pain in the pelvic area?	Yes	No
Do you have pain in your bladder area?	Yes	No
Do you have pain with intercourse?	Yes	No
Do you have vulvar (vaginal opening) pain or burning?	Yes	No
Do you have an abnormal vaginal discharge?	Yes	No
Are you bothered by leakage of stool?	Yes	No
Are you bothered by loss of gas?	Yes	No

How quickly did your symptoms come on?	Gradually	Sudden		
How often are your symptoms?	Constant	Intermittent		
How severe are your symptoms?	Mild	Moderate	Severe	
When did your symptoms begin?	_____ hours / days / weeks / months / years ago			
How have your symptoms changed?	Worsening	Unchanged	Improving	Resolved
Did your symptoms begin after?	Childbirth	Yes	No	
	Urinary tract infection	Yes	No	
	Sexually transmitted disease	Yes	No	
	Bladder procedure	Yes	No	
	Other pelvic procedure(s)	Yes	No	
	If yes, procedure name - _____			

	Abdominal surgery	Yes	No	
	If yes, procedure(s) name - _____			

Please circle which of the following worsen your symptoms:

- | | | |
|------------------------|--------------|-----------------|
| Increased fluid intake | Acidic Foods | Sexual activity |
| Caffeine | Spicy Foods | Stress |
| Alcohol | Full bladder | |

Patient: _____

Please circle and fill out this section ONLY if you have URINARY OR BOWEL LEAKAGE:

(If you have both urinary and bowel leakage, the answers should apply to the more bothersome of the two.)

Please indicate what events precede your leakage:

Coughing	Heavy Lifting	Walking
Sneezing	Exercise	Arriving at home
Laughing	Standing up	At Rest

Does the leaking urine come out with a **spurt** following an activity or is the leakage **sustained** over some time?

Spurt	Sustained loss
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How often does your leakage occur in a week?

Daily	A few times	Not every week
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What type of pads do you usually use?

Light	Medium	Heavy
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How many pads do you, on average, use in a day? _____ pads /day

Does the leakage cause you:

depression? Yes No	to disengage from society? Yes No	sexual dysfunction? Yes No
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Please fill out this section ONLY if you have PAIN or PRESSURE SYMPTOMS:

Please circle which of the following most closely describes your pain:

Sharp	Aching	Burning
Dull	Throbbing	Stinging

Please circle any other areas where you experience pain/pressure currently:

Suprapubic (above pubic bone)	Right Groin	Left Kidney Area (mid back)
Urethra	Outer Vagina	Right Kidney Area (mid back)
Middle Abdomen	Deep vagina	Lower Back - Right side Left side Middle
Left Groin	Tail bone or sacrum	Any other area: _____

Other comments: _____

ALL PATIENTS please circle or fill out remainder of form:

Have you been exposed to any of the following? Chemicals Radiation Tobacco Tuberculosis Secondhand Smoke

Circle if you have had any of the following conditions?

Irritable Bowel Syndrome	Vaginitis	Kidney Disease
Fibromyalgia	Urethral Diverticulum	Bladder Surgery
Chronic Fatigue Syndrome	Radiation Cystitis	Spinal Cord Injury
Systemic Lupus Syndrome	Bladder Cancer	Tuberculosis Cystitis
Vulvodinia	Kidney Infection(s)	Urinary Stones

Previous evaluation for your pelvic health problems:

Performed by a: Family M.D. Internist Gynecologist Urologist Urogynecologist

Name(s) of M.D. _____

When performed: ___days ago ___wks ago ___ months ago ___yrs ago

Circle Studies performed:

Urine Analysis	Sexual Transmitted Disease Testing	Abdominal or Pelvic CT Scan
Recent Urine Culture	Abdominal/pelvic Ultrasound	Abdominal or Pelvic MRI
Urine Cytology	Intravenous Pyelogram (IVP)	Cystoscopy
Bladder Biopsy	Urodynamic Testing	Potassium Sensitivity Testing

Patient: _____

TREATMENTS: Please check as appropriate.

		<u>Previously used?</u>	<u>Currently used?</u>	<u>Was it successful?</u>
DIETARY AND BEHAVIORAL:	Cranberry Juice	_____	_____	_____
	Low Acid Diet	_____	_____	_____
	Alcohol Avoidance	_____	_____	_____
	Caffeine Restriction	_____	_____	_____
	Kegel Exercises	_____	_____	_____
MEDICATION	Vaginal Estrogen	_____	_____	_____
	<u>Antispasmodics:</u>			
	Pyridium/Urelle/Prosed	_____	_____	_____
	Tricyclic antidepressants	_____	_____	_____
	Oxybutynin (Ditropan)	_____	_____	_____
	Oxybutynin Patch (Oxytrol)	_____	_____	_____
	Oxybutynin Gel (Gelnique)	_____	_____	_____
	Tolterodine (Detrol)	_____	_____	_____
	Darifenacin (Enablex)	_____	_____	_____
	Trospium (Sanctura)	_____	_____	_____
	Solifenacin (Vesicare)	_____	_____	_____
	Antihistamines	_____	_____	_____
	Elmiron	_____	_____	_____
	Nonsteroidal anti-inflammatory	_____	_____	_____
	Corticosteroids	_____	_____	_____
	Serotonin reuptake inhibitors	_____	_____	_____
	Gapapentin (Neurontin)	_____	_____	_____
	Opioid analgesics	_____	_____	_____
	Post-coital antibiotics	_____	_____	_____
	Suppressive antibiotics	_____	_____	_____
	<u>Antibiotics:</u>			
	Nitrofurantoin (Macrobid)	_____	_____	_____
	Bactrim, Septra	_____	_____	_____
	Amoxicillin	_____	_____	_____
	Augmentin	_____	_____	_____
	Cephalosporin	_____	_____	_____
	Doxycycline	_____	_____	_____
	Tetracycline	_____	_____	_____
Cipro	_____	_____	_____	
Levaquin	_____	_____	_____	
Physical Therapy	_____	_____	_____	
Pessary Use	_____	_____	_____	
Biofeedback training	_____	_____	_____	
MINIMALLY INVASIVE	Acupuncture	_____	_____	_____
	Hydrodistension	_____	_____	_____
	Bladder Instillation:	_____	_____	_____
	Interstim	_____	_____	_____

Patient: _____ Date: _____

FEMALE MEDICAL HISTORY

Please circle any illnesses that you have:

I have no medical problems

- Alcoholism
- Alzheimer's Disease
- Anxiety
- Arthritis
- Asthma
- Attention Deficit Hyperactivity Disorder
- Bleeding Disorders
- Cancer , Type: _____

- Cervical Disc Herniation
- Chronic Cough
- Deep Vein Thrombosis
- Depression
- Diabetes
- Fibromyalgia
- Gastroesophageal Reflux Disease
- Glaucoma
- Heart Disease
- Hepatitis
- Hyperparathyroidism

- Hypothyroidism
- Lumbar Disc Disorders
- Multiple Sclerosis
- Myocardial Infarction (MI)
- Parkinson's Disease
- Renal Stones
- Rheumatic Fever
- Spinal Cord Injury
- Other medical problem(s), Type: _____

Cerebrovascular Accident (Stroke)

SURGICAL HISTORY

Please circle any surgeries that you have had:

- Abdominal Hysterectomy
- Abdominal Surgery, Type: _____

- Cholecystectomy (removal of the gall bladder)
- Endometrial Ablation
- Facial Surgery, Type: _____

- Sling Procedure
- Tonsillectomy
- Unilateral/Bilateral Salpingo-oophorectomy (removal of ovaries)
- Vaginal Hysterectomy
- Any Other Surgery, Type: _____

- Appendectomy
- Back Surgery
- Bladder Suspension
- CABG X _____ vessels
- Cervical Conization/LEEP
- Cystocele (urinary bladder) Repair
- Dilation/Curettage

- Hip Surgery
- Knee Surgery
- Laparoscopy
- Labial Surgery
- Mastectomy on _____ side
- Vaginal Surgery

MEDICATIONS

Name	Dosage (e.g. mg, gm, cc)	When during day	When started

ALLERGIES: (include medications, iodine, seafood and latex) REACTION

FAMILY HISTORY Please indicate illnesses these family members have had:

Maternal (Mother) Side: _____ Son: _____

Paternal (Father) Side: _____ Sister: _____

Daughter: _____ Brother: _____

Adopted: Yes No

SOCIAL HISTORY Please circle or fill out the appropriate answer(s):

Marital Status: Single Married, happily – Yes No Separated Divorced Remarried Widowed

Number of Children: From this marriage: _____ From any prior marriage: _____

Employment: Vocation: _____ Employed Unemployed Retired Student

Tobacco: Has never smoked

Quit smoking: less than 5 years ago 5 to 10 years ago more than 10 years ago

Number of Years using tobacco _____ Number of Cigarettes per day: 1 5 10 20 30 40

Frequency of Drinks (alcohol): Never drinks Drinks rarely Drinks per day: 1 2 more than 2

Use of Illicit Drugs: Never In the past only Currently

HEALTH MAINTENANCE Colonoscopy Bone Density Health Screen Lab Tests Pap Smear Mammogram

Month and Year of Last: _____

Menstrual History:

Last Menstrual Period (LMP): _____ Birth Control Method Natural Barrier Implant
 Normal Menses Yes No IUD Vaginal Ring Injectable
 Severity of Menstruation Light Normal Heavy Tubal Ligation Oral Contraceptive
 Menopause Yes No Vasectomy

Pregnancy History:

Number of Pregnancies: _____ Largest Birth Weight: _____ pounds
 Number of Vaginal Deliveries: _____ [] delivered with forceps
 Number of C-Section Deliveries: _____ [] delivered by vacuum

REVIEW OF SYSTEMS: Please circle all symptoms that you currently have:

<u>Constitutional</u>	Abdominal Pain	<u>Neurologic</u>
Chills	Nausea	Confusion
Fever	Vomiting	Dizziness
Weight Gain	Constipation	Headaches
	Diarrhea	Impaired Balance
<u>Eyes</u>	Fecal Urgency	Memory Loss
Blurred Vision	Incontinence of Stool	Numbness, location: _____
Double Vision	Rectal Bleeding	Parasthesias (funny feeling on your skin) location: _____
	Black Stool	
<u>Earn/Nose/Throat/Neck</u>		<u>Psychiatric</u>
Dry Mouth	<u>Genitourinary/Nephrology</u>	Anxiety
Hearing Loss	Dysuria (burning with urination)	Depression
Sore Throat	Hematuria (blood in urine)	
	Urinary Incontinence	<u>Endocrine</u>
<u>Cardiovascular</u>	Pain with intercourse (dyspareunia)	Alopecia (loss of hair), location: _____
Chest Pain	Vaginal Dryness	
Palpitations		Change in sex drive (libido)
Edema (swelling), location: _____	<u>Musculoskeletal</u>	Drinking large amounts of fluids (polydipsia)
	Joint aches (arthralgias)	
<u>Respiratory</u>	Back Pain	<u>Hematologic</u>
Cough	Gait abnormality (difficulty walking)	Easy Bleeding
Dyspnea	Hip Pain	Easy Bruising
Dry Cough	Myalgias (muscle ache)	
Productive Cough	Neck Pain	<u>Allergy/Immunology</u>
		Nasal Drainage
<u>Gastrointestinal</u>	<u>Dermatologic</u>	
Anorexia	Rash, location: _____	
Heartburn		

THEODORE V. BENDEREV, M.D. KYM A. KANALY, M.D. PATRICIA A. WALLACE, M.D.

LEGAL NAME - FIRST: _____ **LAST:** _____ **MI:** _____

STREET, CITY, ZIP: _____

HOME PHONE: () _____ **CELL:** () _____ **EMAIL:** _____

SOCIAL SECURITY: _____ **DATE OF BIRTH:** _____ **GENDER:** F M

EMPLOYER: _____ **JOB TITLE:** _____

WORK PHONE: () _____ **MARRIED** **SINGLE** **DIVORCED** **WIDOWED**

YOUR PRIMARY CARE PHYSICIAN: _____ **PHONE:** () _____

WHO REFERRED YOU TO OUR OFFICE: _____

ADDRESS, CITY, STATE, ZIP: _____

LEAVE BLANK IF YOU DO NOT WISH TO REPORT THE FOLLOWING: PREFERRED LANGUAGE: _____

NATIONALITY (CITIZENSHIP): _____ **ETHNICITY:** _____ **RACE:** _____

REQUIRED TO FILL PRESCRIPTIONS: (IF LEFT BLANK WILL DEFAULT TO TOWER PHARMACY)

PHARMACY NAME: _____ **PHONE:** () _____

ADDRESS, CITY: _____ **FAX:** () _____

**PLEASE BRING YOUR INSURANCE CARD AND DRIVER'S LICENSE TO YOUR APPOINTMENT.
IF YOU DO NOT HAVE PROOF OF INSURANCE - PAYMENT IS REQUIRED
AT THE TIME SERVICE IS RENDERED. WE CAN MAKE NO EXCEPTIONS.**

RESPONSIBLE PARTY (OTHER THAN PATIENT)

FIRST NAME: _____ **LAST:** _____ **MI:** _____

RELATIONSHIP TO PATIENT: _____ **DRIVERS LICENSE #:** _____

DATE OF BIRTH: _____ **EMPLOYER:** _____

EMERGENCY CONTACT

NAME: _____ **PHONE:** () _____

RELATIONSHIP TO PATIENT: _____

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE THE INCONTINENCE & PELVIC SUPPORT INSTITUTE (IPSI) TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I HEREBY AUTHORIZE IPSI TO ACCESS, COMMUNICATE AND MAINTAIN MY MEDICATION HISTORY ELECTRONICALLY THROUGH ESCRIBE AND/OR OTHER ELECTRONIC PRESCRIPTION SERVICES IN CONNECTION WITH MY MEDICAL TREATMENT AND IN COMPLIANCE WITH HIPAA REGULATIONS.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. FOR ANY BALANCES OVER 45 BUSINESS DAYS OUTSTANDING, I UNDERSTAND THERE MAY BE A \$5.00 MONTHLY FEE FOR BILLING SERVICE, PLUS INTEREST. A PHOTOCOPY OR SCANNED COPY OF THIS ASSIGNMENT AND RELEASE IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNED: (PATIENT OR PARENT IF MINOR): _____

DATE: _____

THEODORE V. BENDEREV, M.D. KYM A. KANALY, M.D. PATRICIA A. WALLACE, M.D,

FINANCIAL POLICIES

We welcome you to our office. We are able to concentrate on the practice of medicine and provide quality care by having our financial policies understood by our patients and by avoiding confusion or misunderstandings.

Filing insurance claims is a courtesy extended to our patients and is not a guarantee of payment. We will bill insurance claims with a maximum of two insurance carriers per patient. It is important to emphasize that your insurance is a contract between you and the insurance carrier. Insurance plans and contracts change constantly. It is your responsibility to contact your insurance company and verify your benefits and verify that your doctor is a contracted provider in your network PRIOR to your visit. You will be financially responsible for the services rendered if we have not been paid by your insurance carrier within 45 business days.

_____ (patient's initials)

Drs. Benderev, Kanaly and Wallace are participating physicians with Medicare and accept assignment for all covered Medicare services. Medicare pays 80% of approved charges and the patient is responsible for the other 20%, after the annual deductible is met. Our office staff will bill secondary insurance if the responsible party has given permission to the insurance company to have the payment sent to us. Each physician reserves the right to accept Medi-Medi and accept the Medicare payment portion as payment in full.

Drs. Benderev, Kanaly and Wallace are not participating physicians with Medi-Cal and therefore, cannot accept Medi-Cal insurance (including retro-active Medi-Cal coverage). For patients without insurance plans or for patients that are unable to provide an insurance card verifying current coverage, we require payment at the time services are rendered. If you do not have insurance or your insurance company does not pay for services rendered it is the patient's responsibility for payment in full. This also applies to patients requesting services that have insurance plans with which we are not contracted, (e.g., out-of-network coverage).

_____ (patient's initials)

All services rendered by Drs. Benderev, Kanaly and Wallace that are not a covered benefit of your insurance policy are your responsibility to pay. Any patient that is seen or treated without proper authorization from their insurance carrier is responsible for the full charge of the services rendered if no payment is authorized retrospectively. All monies owed by the patient (e.g. co-payments, deductibles, required "out-of-pocket" amounts, non-covered services and co-insurance amounts) are due at the time services are rendered.

_____ (patient's initials)

If your account is placed with a collection agency, due to non-payment, you will be responsible for any additional charges this may incur, including a monthly interest and penalty fee, collection agency fees, attorney fees, court fees, and any other fees associated in collecting the balance due.

_____ (patient's initials)

While we understand there may be times when our patients need to cancel their appointments, we have found it necessary to implement a "Cancellation and No-Show Policy". Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show." A no-show patient scheduled for an office visit may be charged \$40.00. A no-show patient scheduled for a procedure or diagnostic test may be charged \$100.00. No-show charges are not billable to your insurance company and are your responsibility to pay.

_____ (patient's initials)

We are willing to work with any patient requesting a financial payment plan. There will be a \$45 charge for each check that is returned for insufficient funds.

We hope you find this information helpful. Please feel free to ask our office staff if you require any further assistance.

Patient Signature: _____ Date: _____

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner (check all that applies):

___ Home Telephone _____ Email Address _____

- ___ O.K. to leave detailed message, including clinical information with spouse,
family member, and/or on voicemail.
___ Leave message with call back number only.

___ Cell Telephone _____

- ___ O.K. to leave detailed message, including clinical information on voicemail.
___ Leave message with call back number only.

___ Work Telephone _____

- ___ O.K. to leave detailed message, including clinical information on voicemail.
___ Leave message with call back number only.

****NOTE: Uses and disclosures of health information may be permitted without prior consent in an emergency.***

TEXTING

Is it ok if we text you on occasion, for reasons including appointment reminder, and patient/feedback?

- Yes No

PRIVACY PRACTICES ACKNOWLEDGEMENT

****NOTE: A copy of our Privacy Practices Policy is available upon request.***

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Name _____

Birth Date _____

Signature _____

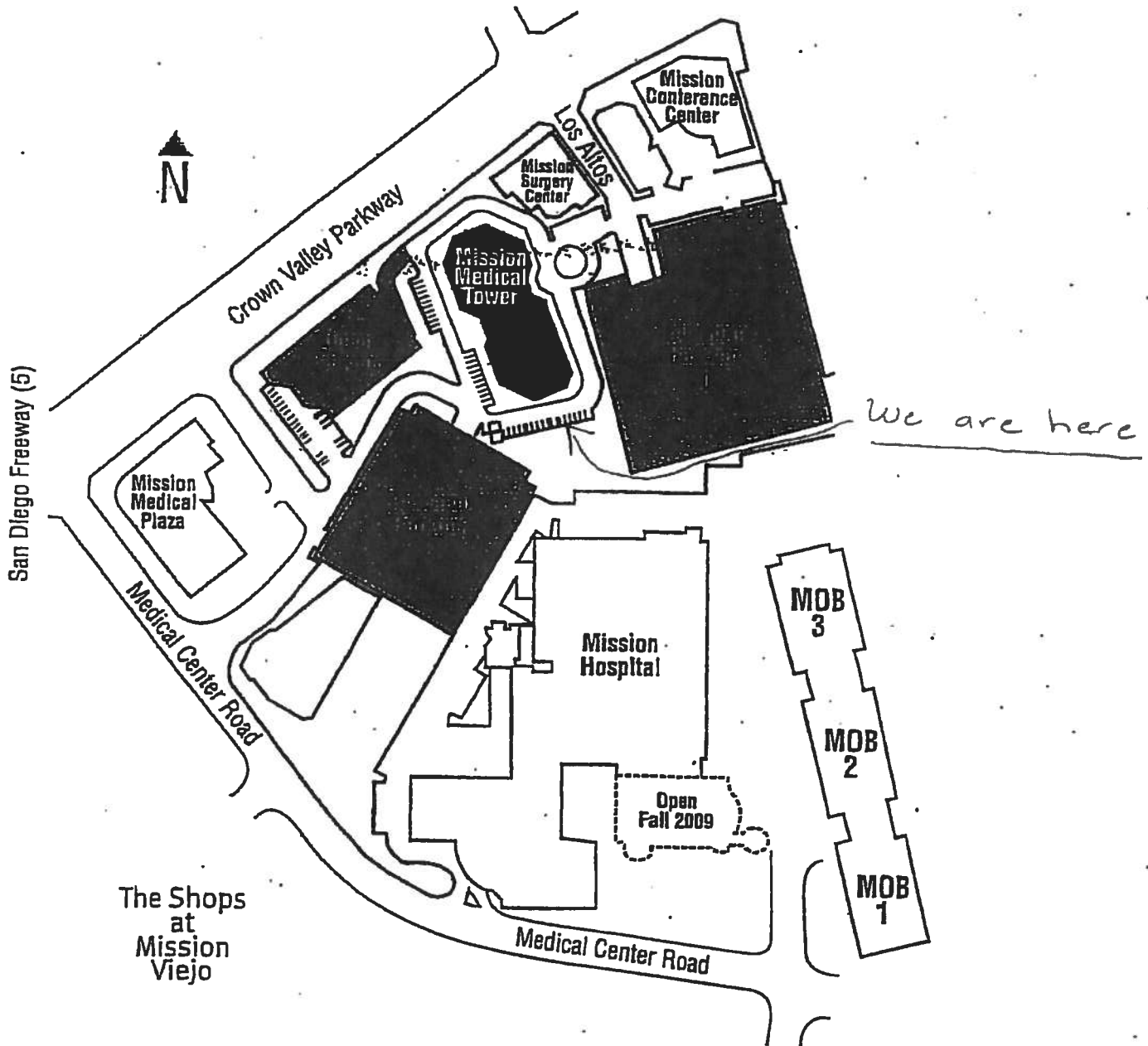
Date _____

****NOTE: This request supersedes any prior request I may have made for confidential patient record disclosures.***

We are located at

**26732 Crown Valley Pkwy
Suite # 327
Mission Viejo, CA
92691**

Phone 949 364-4400



**Mission Campus
Map**

Theodore V. Benderev, M.D.

Patricia A. Wallace, M.D.

Kym A. Kanaly, M.D.

Telephone Extensions to Help Our Patients Navigate Our Phone System

Phone number: **949.364.4400**

ONCE THE GREETING BEGINS SELECT ONE OF THE FOLLOWING EXTENSIONS:

APPOINTMENT SCHEDULING/RECEPTION – select **101 OR 102**

MEDICAL ASSISTANT or for **REFILLS** and **TEST RESULTS** select **107**

SURGERY SCHEDULER and **AUTHORIZATON SPECIALIST**, select **104**

MEDICAL RECORD SPECIALIST, select **103**

BILLING OFFICE, select **949.436.0014**

MANAGER/ADMINISTRATION select **106**

Please leave a message if your party does not answer. Be sure to leave your full name, date of birth and a phone number where you can be reached.

Messages received before 4:30 pm Monday – Thursday will be returned before the close of the business day. Our office closes at 1:30 on Fridays. Messages received before 1:00 pm on Friday, will be returned before the close of the business day.