KIAVASH NIKKHOU, M.D.

415 Rolling Oaks Dr. Suite #260
Thousand Oaks, CA 91361
(805) 309-2555

PATIENT INFORMATION

PLEASE PRINT

PATIENT	Mr. Mrs. Miss/Mrs. Last	First	MI	Home Phone:
Patient's Home Address	City	State	Zip	
Patient Email Address	Cell Phone:			
Social Security #:	Date of Birth	Age	Sex	Driver's License #:
Patient's Employer	Work Address			Work Phone:
Spouse's Name	Spouse's Employer (Name & Address)			Work Phone:
Emergency Contact: (Local/Relative/Friend) Name	Address			Phone:

REFERRED TO THIS OFFICE BY: _____

WHO IS YOUR PRIMARY PHYSICIAN? _____

INSURANCE	PLEASE LIST ALL HEALTH CARE INSURANCE COMPANIES WHICH COVER THIS PATIENT:
PRIMARY:	
Subscriber	Subscriber D.O.B.
SECONDARY:	
Subscriber	Subscriber D.O.B.

RESPONSIBLE PARTY	Mr. Mrs. Miss/Mrs. Last	First	D.O.B.
Address		Phone	
Occupation	Employers Name & Address	Bus. Phone:	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

PLEASE READ & SIGN THE FOLLOWING:

I directly assign all medical / surgical benefits to ***Kiavash Nikkhou, M.D.,*** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE _____ DATE _____

REVISED: 06/20/2019

Dr. Kiavash Nikkhou

Financial Policy

Please read carefully, initial each paragraph, and sign at the bottom.

Fees and Payment Policy

____ Payment is required at the time of your visit. Due to the fact that Dr. Nikkhou is a specialty practice, higher co-pays may be indicated (consult your individual insurance policies for clarification). If you are unable to make your co-payment at the time of your visit, your appointment may need to be rescheduled.

____ While filing insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.

____ Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and the services you intend to receive are covered.

____ In order for us to file a claim, you must present a CURRENT copy of your insurance at each visit and communicate changes in your personal information.

____ Not all services are a covered benefit in all polices, so it is especially important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not pay for. Therefore, we cannot guarantee payment of all claims by your insurance company. *Reduction or rejection of your claim does not relieve you of your financial responsibility.*

____ Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carries is considered fraud and will not be done by our office.

Miscellaneous Charges:

____ Non-Sufficient Funds (NSF) checks are subject to a $30.00 fee (in addition to fees from your bank).

____ You may be charged $100 for missed appointments without 24 hour notification. As a courtesy our office contacts the patient up to two days in advance to an appointment to remind the patient of their future appointment. *This is a courtesy only and is it ultimately the patient's responsibility to keep track of appointments made.*

We accept cash, checks, and major credit cards. Additional fees may apply to special financing arrangements and bad debt collections.

By signing this Financial Policy, you, the guarantor, acknowledge that you have read, understand, and accept the above financial policy.

Patient Name (printed): _____ DOB: _____

Patient/ Guarantor Name (signed): _____ Date: _____

Name of Guarantor (if different from patient): _____

KIAVASH NIKKHOU, M.D. F.A.C.S.
415 Rolling Oaks Drive, Suite 260 • Thousand Oaks, CA 91361
PHONE (805) 309-2555 | FAX (805) 371-4713

Notice of Privacy Practices Acknowledgement Form

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- How this office will use and disclose your protected health information
- Your privacy right with regard to your protected health information
- This office's obligations concerning the use and disclosure of your protected health information

Release of Medical Information:
My preferable method of contact is:

☐ Phone: _____ ☐ Home ☐ Cell ☐ Work

May we leave a detailed message? ☐ Yes ☐ No

☐ Follow My Health Patient Portal

☐ Postal Mail: _____

You may discuss my medical information with:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

_____ _____
Patient or Patient Representative Signature Date

_____
Patient or Patient Representative Printed Name

Urology Health Questionnaire

PLEASE PRINT

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

List any medical issues **previously** or **currently** treated by a physician, including current conditions that require medication:

_____

_____

Do you have or have you ever had:

High Blood Pressure	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Cardiac Disease	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Lung/Pulmonary Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Blood Disease/Disorder	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	If yes, list type of cancer: _____	

Female Patients only: Number of pregnancies: _____ Number and type of delivery: _____

Flu Vaccine: ____/ ____/ _____ Pneumonia Vaccine: ____/ ____/ ____ Colonoscopy: ____/____/ ____

SURGICAL HISTORY

Please list all surgeries and the date:

_____

_____

SOCIAL HISTORY

Do you smoke?	☐ Yes ☐ No	If yes, how may packs per day: _____
Did you ever smoke?	☐ Yes ☐ No	If yes, number of years : _____ Year Quit: _____
Do you drink alcohol?	☐ Yes ☐ No	If yes, how may drinks per day: ___

FAMILY HISTORY

Please list if there are any occurrences of the following in your ***immediate*** family:

Kidney Stone	☐ Yes ☐ No	Relation: _____	☐ Maternal	☐ Paternal
Kidney Cancer	☐ Yes ☐ No	Relation: _____	☐ Maternal	☐ Paternal
Blood Disease/Disorder	☐ Yes ☐ No	Relation: _____	☐ Maternal	☐ Paternal
Heart Disease	☐ Yes ☐ No	Relation: _____	☐ Maternal	☐ Paternal
Prostate Cancer	☐ Yes ☐ No	Relation: _____	☐ Maternal	☐ Paternal
Bladder Cancer	☐ Yes ☐ No	Relation: _____	☐ Maternal	☐ Paternal
Diabetes	☐ Yes ☐ No	Relation: _____	☐ Maternal	☐ Paternal
Stroke	☐ Yes ☐ No	Relation: _____	☐ Maternal	☐ Paternal

Patient Medication List

PLEASE PRINT

Patient Name:_____ Date of Birth:_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list the medications and reactions: _____

_____

Please list all medications you are taking (Prescription, Over the Counter, Vitamins, and Supplements):

Name:	Strength:	How Often:	Reason for Medication:

Do you take any blood thinners? ☐ Yes ☐ No Do you take Aspirin? ☐ Yes ☐ No

Pharmacy:

Local pharmacy (please list cross streets if known): _____

Mail Order Pharmacy: _____

Review of Systems

Patient Name: _____
Date of birth: _____

General: Height: _____ Weight: _____
General good health: ☐ Yes ☐ No
Recent weight loss: ☐ Yes ☐ No

Head-Eyes-Ears-Nose-Throat:
Dizziness ☐ Yes ☐ No
Fainting ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Hearing impairment ☐ Yes ☐ No

Gastrointestinal:
Nausea or vomiting ☐ Yes ☐ No
Frequent diarrhea ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Liver disease ☐ Yes ☐ No

Genitourinary:
Loss of urine/incontinence ☐ Yes ☐ No
Frequent urination ☐ Yes ☐ No
Burning w/ urination ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No
Sexual problems ☐ Yes ☐ No

Endocrine:
Thyroid disease ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No

Cardiovascular:
Heart disease ☐ Yes ☐ No
Chest pain ☐ Yes ☐ No

Respiratory:
Pulmonary disease ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No
Asthma/wheezing ☐ Yes ☐ No

Musculoskeletal:
Chronic back problems ☐ Yes ☐ No
Difficulty walking ☐ Yes ☐ No
Muscle weakness ☐ Yes ☐ No

Neurological-Psychiatric:
Seizures ☐ Yes ☐ No
Paralysis ☐ Yes ☐ No
Strokes ☐ Yes ☐ No
Psychiatric care ☐ Yes ☐ No

Hematologic:
Slow to heal ☐ Yes ☐ No
Bleeding or bruising tendencies ☐ Yes ☐ No
Blood transfusions ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Deep venous thrombosis ☐ Yes ☐ No