THEODORE BENDEREV, M.D.

BOARD CERTIFIED UROLOGIST
IPSI- A Medical Corporation
26732 Crown Valley Pkwy, Suite 327
Mission Viejo, CA 92691
Phone 949-364-4400

Dear _____:

Thank you for choosing to schedule your appointment with Dr. Theodore Benderev.

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 and bring this information back with you at the time of your appointment. **Please do not mail these forms back to our office.**

If your paperwork is incomplete or forgotten, you may arrive 30 minutes early to fill out paperwork or we will have to reschedule your appointment. Also, please bring along your insurance card and any co-pay required for your visit.

We are located at 26732 Crown Valley Parkway in Suite #327. Please feel free to call us at (949) 364-4400 if you have any questions.

Please remember to bring an athletic supporter (jock strap) with you at the time of your procedure.

Your appointment is on _____ at _____.

Thank you for scheduling with us and we look forward to serving you.

Sincerely,

Theodore Benderev, M.D.

THEODORE V. BENDEREV, M.D.

PLEASE COMPLETE IN ITS ENTIRETY PATIENT INFORMATION SHEET

(All information is necessary to bill your insurance for you) DATE:_____

LEGAL NAME - FIRST:_____ LAST:_____ MI____

DO YOU WISH TO BE ADDRESSED BY ANOTHER NAME? IF YES, INDICATE NAME:_____

STREET:_____ APT.#_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE # ( )_____ DRIVER'S LICENSE:_____ EXP. DATE:_____

IF WE CAN FAX AND/ OR E-MAIL MATERIAL TO YOU, PLEASE GIVE US YOUR FAX AND/ OR E-MAIL ADDRESS:

CELL#: ( ) _____ FAX# ( ) _____ E-MAIL _____

SOCIAL SECURITY: _____ DATE OF BIRTH: _____ SEX: F M

EMPLOYER: _____ POSITION: _____

EMPLOYER ADDRESS: _____

WORK PHONE # ( ) _____ MARRIED_____ SINGLE_____ DIVORCED_____ WIDOWED _____

YOUR PRIMARY CARE PHYSICIAN: _____ PHONE # ( )_____

WHO REFERRED YOU TO OUR OFFICE? DR. / MR. / MRS. / MS. _____

IF NOT REFERRED, HOW DID YOU FIND OUT ABOUT US? _____

INSURANCE INFORMATION: (PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT)

IF YOU DO NOT HAVE PROOF OF INSURANCE, PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED.

MEDICARE # (IF APPLICABLE): _____

OTHER INSURANCE ID # _____ GROUP # _____ INSURANCE CO: _____

RESPONSIBLE INSURED PARTY: (IF OTHER THAN PATIENT)

FIRST NAME: _____ LAST: _____ MI:_____

SOCIAL SECURITY #_____ DATE OF BIRTH: _____

EMPLOYER: _____ DRIVER'S LICENSE # _____

RELATIONSHIP TO PATIENT: _____ SPOUSE'S NAME: _____ SPOUSE'S D.O.B._____

IN CASE OF EMERGENCY:

NOTIFY: _____ PHONE # ( )_____

RELATIONSHIP TO PATIENT:_____

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE THE DOCTOR WHOSE NAME APPEARS ABOVE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

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. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNED: (PATIENT OR PARENT IF MINOR) _____ DATE: _____

THEODORE V. BENDEREV, M.D.
IPSI – A Medical Corporation

FINANCIAL POLICIES

We welcome you to The Incontinence and Pelvic Support Institute (IPSI). 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.

As a courtesy to our patients, 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. Our billing experience has taught us that while filing insurance claims is a courtesy extended to our patients, it is not a guarantee of payment. You will be billed directly for the services rendered if we have not been paid by your insurance carrier within 45 business days. You will then be responsible for the bill.**

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. For services not covered by Medicare, a separate arrangement can be made.

Drs. Benderev is not a 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 who have insurance plans with whom we are not contracted, (e.g., out-of-network coverage). _____ **(patient's initials)**

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.

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 collection agency fees, attorney fees, court fees, and any other fees associated in collecting the balance due.

For patients having surgery, we are happy to provide an estimate of surgical charges. The estimate is based upon present expectations of the tests/procedures and/or services that will be required for your care. Additional services may become necessary and we will attempt to inform the patient as the need for additional services are identified.

Any patient that is seen or treated at IPSI without proper authorization from their insurance carrier is responsible for the full charge of the services rendered if no payment is authorized retrospectively.

Any services rendered by the IPSI that are not a covered benefit of your insurance policy are your responsibility to pay. Our staff will assist you to the best of their knowledge in dealing with your insurance company but it is your responsibility to know and understand your insurance policy.

We accept cash, check, VISA or Master Card. We are willing to work with any patient requesting a financial payment plan. There will be a $20 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:_____

PRECAUTIONS FOR SURGERY

All patients anticipating surgical procedures must stop taking aspirin and aspirin products as well as ibuprophen for **2 weeks** prior to procedure. These drugs and other nonsteroidal anti-inflammatory drugs are anticoagulants which can cause bleeding problems during and following the procedure.

THE FOLLOWING COMPOUNDS ARE TO BE AVOIDED: FOR 10 TO 14 DAYS PRIOR TO SURGERY.

(Contact your general physician if there is any question whether you need the medicine.)

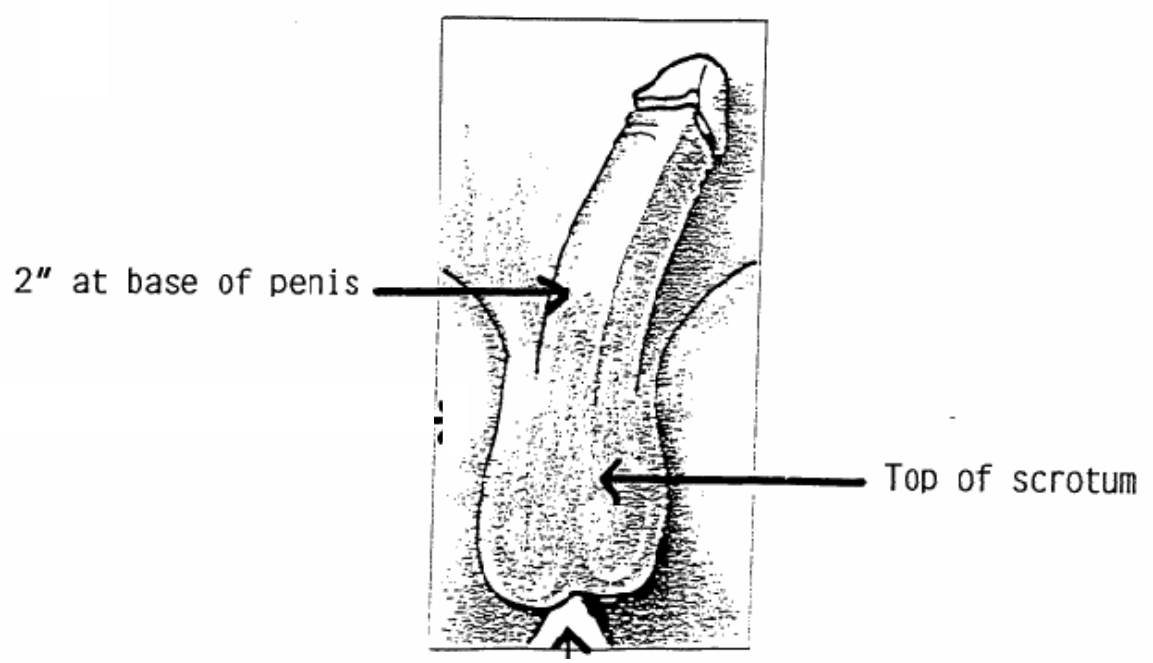
ADVIL	COPE	IBUPROPHEN	RELAFEN
ALKA	CORICIDIN	INDOCIN	ROBAXISAL
ALLEVE	DAMASON	LODINE	SALTFLEX
SELTZER	DARVON	MEASURIN	SINE AID
ANACIN	COMPOUND	MEDIPRIN	STENDIN
ANAPROX	DISALCID	MIDOL	SINE OFF
ARTHOTEC	DOLOBID	MOBIC	SUPAC
ASCRIPITIN	DRISTAN	MOTRIN	SYNALGOS
ASPRIN	DURAGESIC	NALFON	PAC
BAYER	ECOTRIN	NAPROSYN	SYNALGOS DC
ASPRIN	EMPIRIN	NAPRELAN	TOLECTIN
BEXTRA	EQUAGESIC	NORGESIC	TORADOL
BUFFERIN	EXCEDERIN	NUPIN	TRILAMINCAN
CAMA	FELEDENE	ORUDIS	TRILISATE
CATAFLAM	FIORINAL	ORUVAIL	VANQUISH
CELEBREX	FOUR WAY	PAC	VIOXX
CHERACOL	COLD	PANALGESIC	VOLTAREN
CLINORIL	HALFPRIN	PERCODIN	
CONGESPRIN	HALTRAN	PONSTEL	

ALSO AVOID "HERBAL" COMPOUNDS PRIOR TO SURGERY.

A number of herbal remedies have side effects that could complicate a surgical procedures by inhibiting blood clotting, affecting blood pressure, or interfering with anesthetics. Ginkgo biloba, feverfew, garlic, ginger, and ginseng have all been shown to interfere with the function of platelets. The use of herbal preparations in the United States has risen dramatically over the past decade. Although we do not have the exact rate of complications form herbs, the potential for them to cause a problem is real.

SHAVING INSTRUCTIONS FOR THE DAY OF VASECTOMY

On the day of the procedure you should shave the hair 2 inches at the base of the penis and the top of the scrotum.



PLEASE SHAVE ON THE DAY OF THE PROCEDURE
<u>NOT</u> THE NIGHT BEFORE

Theodore Val Benderev, M.D.
Urology
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26732 Crown Valley Pkwy, Suite 327
Mission Viejo, CA 92691
Phone 949-364-4400

PATIENT VASECTOMY QUESTIONNAIRE

Patient Name: _____

Date: _____

Referred by: _____

Describe the health care that you are seeking care today:
(Chief Complaint) _____

Your age: years old

This section for doctor use only

VASECTOMY HISTORY (Begin Here)

Have you had an infection in the testicle area? Yes No

Have you ever been injured in the scrotal area Yes No

If so, please describe_____

_____

Have you ever had an inguinal hernia repair Yes No

Have you had prostatitis (inflamation of the prostate) before? Yes No

If yes, what medication were you treated with and for how long?

_____

_____

Is there anyone in your family who has had Prostate cancer? Yes No

If so, which relative was is he? _____

Are you having sexual problems?
Yes No

Have you had any conditions affecting the urine, kidneys, bladder, prostates, testicles or penis?

_____

_____

Patient Name:

What main Internet search engine do you use?

_____

Have you had reviewed Vasectomy.com for information on vasectomies?

Yes No

What, if any, additional questions or concerns do you have?

_____

_____

_____

Your Past Medical & Surgical History:

Illnesses – please circle all that apply and list others:

High blood pressure	Diabetes	Bleeding problems	Kidney problems
Heart disease	Arthritis	Liver disease/hepatitis	Stomach ulcers/reflux
Heart arrhythmia	Osteoporosis	Glaucoma	Thyroid problem
Cancer type_____	Stroke	Heart murmur	Venereal diseases

Other_____

Other hospitalizations_____

Operations – list any operations you have had and the year of the procedure

_____

_____

_____

_____

Fractures & Injuries – list any fractures or serious accidents you have had:

_____

Medications – list all prescription and non-prescription medications you use with the **doses**:
(include aspirin, hormones, birth control pills, laxatives, vitamins, calcium and others)

_____

_____

_____

_____

_____

ALLERGIES (include medication, iodine, seafood, latex & others) **REACTION**

_____ _____

_____ _____

_____ _____

_____ _____

Your Family's Medical History – list illnesses of your blood relatives (include heart disease, diabetes, cancer, high blood pressure, kidney disease, gout, osteoporosis, bleeding problems)

Living relations	**Illness**	**Deceased relations**	**Illness/Cause of death**
_____		_____	
_____		_____	

Patient Name:

Social History – please circle or fill in the blank

Tobacco use: Never Presently Past (year quit _____)
Alcohol use: None Occasional Regular _____
Your occupation: _____ Are you retired? Yes No

Marital status: Single Married Divorced Widowed Religious reference (optional)_____
Your partner's name: _____ Partner's occupation_____
How long have you been married to your present wife? ____ years
Is the marriage stable? Y or N

Children by this marriage?

Name	Ages	Sex	Health

Children from previous marriage:_____ Ages:_____

How many children are living with you: _____

Complete Review of Systems Circle any current or recent problems with the following:

CONSTITUTIONAL		
Any recent weight change	Y	N
Fever or chills	Y	N
Headache	Y	N
CARDIOVASCULAR		
Chest pain or angina	Y	N
Swelling of legs	Y	N
Varicose veins	Y	N
HEMATOLOGIC/LYMPHATIC		
Easy bruising or bleeding	Y	N
Anemia	Y	N
Swollen glands	Y	N
MUSCULOSKELETAL		
Joint pain	Y	N
Back pain	Y	N
Neck pain	Y	N
NEUROLOGIC		
Numbness/tingling	Y	N
Tremors	Y	N
Seizures	Y	N
Dizziness	Y	N

INTEGUMENTARY(SKIN)		
Skin rash	Y	N
Itching	Y	N
RESPIRATORY		
Cough	Y	N
Wheezing	Y	N
Shortness of breath	Y	N
GASTROINTESTINAL		
Abdominal pain	Y	N
Nausea or vomiting	Y	N
Blood in stool	Y	N
Black stool	Y	N
Recent change in stool	Y	N
Heartburn/indigestion	Y	N
Hemorrhoids	Y	N
GENITOURINARY		
Leaking urine	Y	N
Frequent urinary infections	Y	N
Urinary retention	Y	N

