



# Coastal Cardiology



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|   |           |   |   |  |                                     |
|---|-----------|---|---|--|-------------------------------------|
| Today's Date:   |           | Primary Care MD   |   | <input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Update |                                     |
| <b>PATIENT INFORMATION - PLEASE PRINT</b>   |           |   |   |  |                                     |
| FULL LEGAL NAME (FIRST)<br><small>(MIDDLE)</small>  |           |   | FULL LEGAL NAME (LAST)<br><small>(LAST)</small>                                       | NAME NORMALLY USED (NICKNAME)  |                                     |
| REQUIRED - STREET ADDRESS (NUMBER)<br><small>(NUMBER)</small>   |           | STREET<br><small>(STREET)</small>   |   | APT #<br><small>(APT #)</small>  | SPACE #<br><small>(SPACE #)</small> |
| PO BOX ADDRESS (NUMBER)<br><small>(NUMBER)</small>  |           | STREET<br><small>(STREET)</small>   |   | APT #<br><small>(APT #)</small>  | SPACE #<br><small>(SPACE #)</small> |
| CITY  | STATE     | ZIP CODE  | SOCIAL SECURITY #   |  | HOME PHONE #                        |
| EMAIL ADDRESS:  |           |   |   | CELL PHONE #   |                                     |
| DATE OF BIRTH (MO/DAY/YR)   | AGE       | SEX<br><input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE                           | MARITAL STATUS<br><input type="checkbox"/> MARRIED<br><input type="checkbox"/> SINGLE |  | OCCUPATION                          |
| EMPLOYER NAME   |           | EMPLOYER STREET ADDRESS<br><small>(CITY)</small> <small>(STATE)</small> <small>(ZIP CODE)</small> |   |  |                                     |
| BUSINESS PHONE  | EXTENSION | YOUR DRIVER'S LICENSE#  |   | STATE  |                                     |
| <b>SPOUSE'S, PARENT'S, AND/OR GUARANTOR'S INFORMATION</b>   |           |   |   |  |                                     |
| FULL LEGAL NAME (FIRST)<br><small>(MIDDLE)</small>  |           |   | FULL LEGAL NAME (LAST)<br><small>(LAST)</small>                                       | OCCUPATION   |                                     |
| ADDRESS (IF DIFFERENT THAN ABOVE)<br><small>(CITY)</small> <small>(STATE)</small> <small>(ZIP CODE)</small>   |           |   | HOME PHONE  |  |                                     |
| EMPLOYER (STREET ADDRESS)<br><small>(CITY)</small> <small>(STATE)</small> <small>(ZIP CODE)</small>   |           | BUSINESS PHONE  |   | EXTENSION  |                                     |
| <b>CONCERNING INSURANCE</b>   |           |   |   |  |                                     |
| MARK HERE IF <input type="checkbox"/> SPOUSE IS POLICY HOLDER <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDI-CAL <input type="checkbox"/> HMO <input type="checkbox"/> WORK COMP<br>DATE OF INJURY _____ |           |   |   |  |                                     |
| PRIMARY INSURANCE CO. HERE  |           | GROUP NUMBER  |   | ID NUMBER  |                                     |
| INSURED'S NAME  |           | DATE OF BIRTH   |   | INSURANCE CO. ADDRESS  |                                     |
| SECONDARY INSURANCE CO. NAME  |           | GROUP NUMBER  |   | ID NUMBER  |                                     |
| INSURED'S NAME  |           | DATE OF BIRTH   |   | INSURANCE COL ADDRESS  |                                     |
| <b>EMERGENCY INFORMATION</b>  |           |   |   |  |                                     |
| PERSON TO NOTIFY IN CASE OF EMERGENCY (NOT LIVING WITH YOU)   |           |   |   | RELATIONSHIP   |                                     |
| ADDRESS (NUMBER)<br><small>(NUMBER)</small>   |           | STREET<br><small>(STREET)</small>   |   | APT #<br><small>(APT #)</small>  | SPACE #<br><small>(SPACE #)</small> |
| CITY  | STATE     | ZIP CODE  | HOME PHONE  |  |                                     |

**Please complete - OVER**

**PAYMENT OF SERVICES, INSURANCE BENEFITS, AUTHORIZATION TO RELEASE/OBTAIN INFORMATION**

I hereby authorize ***Coastal Cardiology, A Medical Corporation*** to obtain any medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any medical records concerning my care to any physician, hospital or other health care professional providing care to me. Additionally, I authorize the Practice to release any medical records concerning my care to my medical insurance company (i.e. Medicare, Medicaid, any insurance company, third party administrator, or managed care company) except as specifically provided below \_\_\_\_\_.

I am aware that the records may contain information relating to psychiatric or psychological testing, physical abuse and/or alcohol abuse and/or HIV test results if any.

I realize that I am responsible for payment of all medical service rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier. If I am not eligible or services rendered are not covered benefits under the terms of my employers Medical and Hospital Subscriber Agreement, I am liable for all charges for services rendered.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

By refusing to sign the above, I understand that my insurance company will not be billed by Coastal Cardiology and I am responsible for payment at the time of service.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS**

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize the Practice to release verbally and/or photo copies of any or all medical and billing information, pertaining to my medical care, to the following individuals: I understand this information may only be released to the individual after proper identification has been presented to the business office. The authorized person may be requested to obtain this information by appearing in person at the business office.

I do **not** authorize the Practice to release any or all information concerning my medical care to any individual except as set forth above.

I authorize the Practice to release verbally and/or photo copies of any or all information concerning my medical care to the following individuals:

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ DOB \_\_\_\_\_

PRINT NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ DOB \_\_\_\_\_

PRINT NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Patient's Account Number:** \_\_\_\_\_ **\*Unique Identification** \_\_\_\_\_

**Coastal Cardiology  
HEALTH HISTORY  
(Confidential)**

Name \_\_\_\_\_ Date \_\_\_\_\_ Referring Dr. \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Why are you seeing a cardiologist? \_\_\_\_\_

Coastal Cardiology Physicians Name you are seeing today: \_\_\_\_\_

**History and Physical – Please (X)**

**Heart problems or symptoms:**

- Heart Attack
- Angina
- Heart Murmur
- Rheumatic Fever
- Abnormal Rhythm (arrhythmia)
- Palpitations, irregular heartbeats
- Fainting
- Enlarge Heart
- Chest Pains or Pressure
- Shortness of Breath
- Dizziness
- Swollen Legs
- Heart Failure
- Blue Lips or Fingernails
- Leg Cramps when you walk

**Have you ever had:**

- A Stress Test (Treadmill)
- An Echocardiogram
- Cardiac Catheterization
- Coronary Angioplasty (balloon)
- Coronary Bypass Surgery
- Valve Surgery
- Electrophysiology Study/Proc.
- a Pacemaker
- Implanted Defibrillator
- ECG
- 24 Holter Monitor
- Event Recorder

**Check if you have:**

- High Blood Pressure
- High Cholesterol
- Ever Smoked
- Diabetes
- Do you exercise (walking)

**Close family member with:**

- Heart Attack
- Angina

**If a Woman have you:**

- Passed Menopause  
if so what age: \_\_\_\_\_
- Take Estrogen replacement

please tell us anything else about your heart: \_\_\_\_\_

**Current Medications:**

Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medications:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_
- 8) \_\_\_\_\_

**Allergies:**

Are you allergic to any medications?  Yes  No

List medications to which you are allergic: \_\_\_\_\_

What kind of reaction did you have? \_\_\_\_\_

**Past Medical History – Please (X) any symptoms you have or have had in the past year.**

**Constitutional**

- Lack of energy
- Trouble sleeping
- Loss of Appetite
- Weight changes
- Fever

**HEENT**

- Blurred vision
- Glaucoma
- Cataracts
- Buzzing or ringing in ears
- Hay fever
- Sinus Problem

**Respiratory**

- Wheezing
- Cough
- Coughing blood
- Asthma
- Tuberculosis

**Please complete - OVER**

**Please complete - OVER**

HEALTH HISTORY Continued:

Name: \_\_\_\_\_

**Digestive**

- Indigestion
- Change in bowel habits
- Bloody or tarry stools
- Jaundice
- Liver problems
- Ulcers
- Gallstones

**Dermatological**

- Rash
- Itching
- Other skin problems

**Neurological**

- Paralysis (even temporary)
- Stroke
- Numbness
- Loss of balance
- Dizziness

**Hematological**

- Bleeding
- Easy bruising
- Risk Factors for HIV
- Anemia
- Cancer

**Urinary**

- Frequency
- Infections
- Stones
- Bladder incontinence

**Men**

- Prostate problems
- Night-time urination

**Women**

- Abnormal Menstrual Periods
- Could you be pregnant?

**Psychiatric**

- Unusual thoughts
- Nervousness
- Crying or sadness
- Depression
- Suicide attempts

**Have you had any operations?**

- 1) \_\_\_\_\_ 2) \_\_\_\_\_
- 3) \_\_\_\_\_ 4) \_\_\_\_\_

**Are you being treated now or have been treated for any illness?**

- 1) \_\_\_\_\_ 2) \_\_\_\_\_
- 3) \_\_\_\_\_ 4) \_\_\_\_\_

**Musculoskeletal**

- Joint pain swelling or redness
- Arthritis
- Back pain
- Muscle aches
- Muscle tenderness
- Gout

**Female Reproductive**

- Breast lumps
- Recent mammogram
- Pap Smear &/or Pelvic Exam

**Endocrinology**

- Thyroid disorder
- Diabetes
- Excess thirst
- Excess hunger
- Excess urination

**Social History:**

**Marital Status:**  Single  Married  Widowed  Divorced

With whom do you live? \_\_\_\_\_

Occupation \_\_\_\_\_

Leisure Activities \_\_\_\_\_

Education Level \_\_\_\_\_

**Health Habits:**

Do you smoke?  Yes  No

How many packs per day? \_\_\_\_\_

For how many years? \_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_

Do you use any drugs? \_\_\_\_\_

**Family History:**

Check if any close family members (parents, brothers and sisters, children) have:

- |  |                                 |                                 |                                  |                                 |                                |
|--|---------------------------------|---------------------------------|----------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Child |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Child |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Child |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Child |

Are there any other health problems in your family? \_\_\_\_\_

**Hospitalizations:**

| Year | Hospital | Reason |
|------|----------|--------|
|      |          |        |
|      |          |        |

**Please complete**

**Acknowledgement of Receipt of Notice of Privacy Practices**

***Coastal Cardiology, A Medical Corporation***

1941 Johnson Suite 101 (Main office)  
San Luis Obispo, CA 93405

**Administrator & All Supervisors (805) 782-8844 Privacy Officers**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Account # \_\_\_\_\_

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

Parent of guardian of minor patient

Guardian or conservator of an incompetent patient

Name & Address of Patient: \_\_\_\_\_

**Notice of Privacy Practices Acknowledgments Tracking Information**

***For Office Use Only:***

Date received: \_\_\_\_\_

Processed by: \_\_\_\_\_

Practice Follow-up: Yes  No

Date of Practice Follow-up: \_\_\_\_\_

***Complete the following only if the Patient refuses to sign the Acknowledgment:***

Efforts to obtain: \_\_\_\_\_

Reasons for refusal: \_\_\_\_\_



310 South Halcyon Rd., Ste 105 Arroyo Grande, CA 93420  
1941 Johnson Ave, Ste. 101, San Luis Obispo, CA 93401 (Office Visits)  
1941 Johnson Ave, Ste. LL 102, San Luis Obispo, CA 93401 (Procedures)  
295 Posada Lane, Suite A, Templeton, CA 93465

Due to the rising practice expenses and the demands on our staff of increasing paperwork and telephone calls, it has become necessary to institute the following charges.

Missed Appointments without 24 hour notice ..... \$ 25  
Missed Nuclear Test.....\$200  
Missed Echo or Stress Echo Tests.....\$50

Forms Fees (outside of office visit)

- Disability \$ 25
- Life insurance \$ 25
- Jury Duty \$ 20
- DMV Placard \$ 20
- Assisted Living Forms \$ 25
- Typed letters (Any reason) \$ 25
- Medical Records- depending on the size \$ 16-25
- Copies of Test Images \$ 25

Outside Office Fees

- Statement Re-Billing \$ 5.00
- Returned Check Fee \$25.00

I understand that these are services not covered by my insurance which I will be responsible for.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Account Number