Coastal Cardiology
ICAEL Accredited Echocardiography Laboratory
ICANL Accredited Nuclear Cardiology Laboratory

Patient Registration Form

Please complete this form in black or blue ink only. Illegible forms will be returned.

Cardiologist: _____, M.D., F.A.C.C. Primary Care Physician: _____

PATIENT INFORMATION	Acct#:	Gender:☐F ☐M	DOB: _ _/_ _/ _ _	SSN:
	First Name:		Middle Initial:	Last Name:
	Previous Name(s):			Nickname (Goes By):
	Address:			City, State & Zip:
	Mailing Address: ☐ Same as above			City, State & Zip:
	Are you in a Skilled Nursing Facility or Hospice Program? ☐Y☐N			If yes, which?
	Do you have an Advanced Directive? ☐ Yes (if so, please provide a copy for our records) ☐ No			
	Home#:	Work#:		Cell#:
	Preferred Method of Contact: ☐ Text ☐ Email / Portal ☐ Letter ☐ Call			
	Email Address:			Primary Language:
	Please check the box(es) that describe your race: ☐American Indian or Alaska Native ☐Asian ☐Black ☐White ☐Decline to Specify ☐Other:			
	Please check the box(es) that describe your ethnicity: ☐ Latino ☐ Non-Latino ☐ Decline to Specify			
	☐ Employer:	☐ Retired ☐ Not Employed		Marital Status:
	Employer Address:			Employer Phone #:
INFORMATION	**Please be aware our receptionists will ask to review current identification and insurance cards.**			
	Primary Insurance:			Phone:
	Subscriber ID / Group:			Subscriber Name: ☐ Self
	Subscriber's DOB: _ _/_ _/ _ _	Subscriber's Gender:☐F☐M		Relation to Patient:
	☐ Secondary Insurance:	☐No Secondary		Phone:
	Subscriber ID / Group:			Subscriber Name: ☐ Self
	Subscriber's DOB: _ _/_ _/ _ _	Subscriber's Gender:☐F☐M		Relation to Patient:
CONTACTS	Emergency Contact's Name:			
	Date of Birth: _ _ / _ _/ _ _	Phone:		Relation to Patient:
	Address:			
	Alternate Emergency Contact's Name:			
	Date of Birth: _ _ / _ _/ _ _	Phone:		Relation to Patient:
	Address:			

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Coastal Cardiology's physicians and physician assistants are licensed to practice in the state of California. I hereby authorize medical treatment by the staff and physicians of Coastal Cardiology, A Medical Corporation. I hereby authorize Coastal Cardiology, A Medical Corporation to exchange any medical records concerning my care with any physician, hospital or other health care professional who has provided or will provide me with medical care, including records from Surescripts, CommonWell Health Alliance and Carequality. Additionally, I authorize the practice to release any medical records concerning my care to my medical insurance company. I am aware that medical records may include sensitive and privileged information. I am aware that without this authorization Coastal Cardiology will not bill my insurance company and I am responsible for full payment at the time of service.

I am aware of the privacy standards of Coastal Cardiology and my rights and responsibilities as a patient under the Healthcare Portability Act of 1996 (HIPAA) and other governmental regulations. Should I request additional information, it will be provided by Coastal Cardiology staff. Otherwise, all exchanges of information including prescription history, medical history, and conversations about my condition will be in accordance with stipulated policies and procedures. I have authorized the practice to release any and all information concerning my medical care to the individuals named as emergency contact and alternate emergency contact. This permission may be revoked at any time.

I realize that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier. I hereby assign insurance benefits to Coastal Cardiology for all services rendered by Coastal Cardiology. I am liable for all charges for services rendered. This authorization shall continue and be in full force and effect until revoked by me in writing.

➲Signature: _____ Date: _____

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Coastal Cardiology physicians will review your health history and conduct an initial evaluation to determine if you are a suitable candidate and whether the practice will accept you as a patient.

Reviewed By (Coastal Cardiology Employee): _____ Date: _____

Coastal Cardiology
HEALTH HISTORY
(Confidential)

Name: _____ Date: _____ Account#: _____
DOB: _____ Referring Physician: _____
Why are you seeing a cardiologist? _____
Which Coastal Cardiology physician are you 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
- ☐ Holter Monitor
- ☐ Event Recorder

Please tell us anything else about your heart: _____
_____

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, at what age: _____
- ☐ Take Estrogen replacement

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 both sides of this form.

Continued Health History, 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

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

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)_____

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:

☐ Heart Problems	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child
☐ Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Child

Are there any other health problems in your family?_____

Hospitalizations:

Year	Hospital	Reason

Please complete both sides of this form.

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For Your Information

Please take a moment to carefully review the following pages. You will be asked to confirm your understanding of all current fees, our Notice of Privacy Practices and our Financial Policy at your appointment.

FEES

Due to rising practice expenses and interconnected demands on our staff, it has become necessary to institute the following charges. Please note that repeated no shows, rescheduling or failure to provide payment for services rendered may result in discharge from the practice for non-compliance. The charges described below are not covered by insurance and are as a result, the sole responsibility of the patient. These fees are published on the Coastal Cardiology website and a current listing of fees may also be requested at any appointment. Additional inquiries may be directed to the Coastal Cardiology Business Office at 805/540-5865.

Missed Appointments without 24-hour notice

Missed Office Visit	$ 25.00
Rescheduled Office Visit*	$ 25.00
Missed Nuclear Test	$ 200.00
Missed Vascular, Echo or Stress Echo	$ 50.00

*This includes appointments changed when necessary labs were not completed

Forms Fees (outside of office visit)

As a specialty practice, we are not always the appropriate provider to complete forms. Prior approval by the physician is required before a form is brought to our office for completion. We welcome phone calls to clarify our policy.

Disability	$ 25.00
Life Insurance	$ 25.00
Jury Duty	$ 20.00
DMV Placard	$ 20.00
Assisted Living Forms	$ 25.00
Typed Letters (any reason)	$ 25.00
Medical Records (depending on the size)	$ 16.00 and up
Copies of Test Images	$ 25.00

Miscellaneous Fees

Statement Re-Billing	$ 5.00
Returned Check Fee	$ 25.00
After Hours / Answering Service Calls	$ 25.00
Financial Transaction History (Five Pages or More)	$ 25.00

ACKNOWLEDGEMENT & RECEIPT OF NOTICE OF PRIVACY POLICIES AT COASTAL CARDIOLOGY

Prior to your appointment, we ask all patients to review a copy of this medical practice's Notice of Privacy Practices. A copy of the current notice is also posted in the reception area, available

on our website and may be requested at any appointment. Questions or concerns about privacy may be brought to the attention of Coastal Cardiology staff by calling 805/782-8844.

FINANCIAL POLICY

Payment is expected at the time of service as specified below. Payment may be provided in various methods, including cash, check, Visa, MasterCard and Discover. If you are unable to pay at the time of service, the service may be rescheduled.

COPAYS, COINSURANCE AND DEDUCTIBLES

It is the financial policy of this practice to collect all co-pays, co-insurance and deductibles at the time of service, before the service is performed. An estimate of the deductible due will be provided before the service. An exact number may be difficult to obtain given claims in process, etc. Any overpayment will be refunded once the insurance adjudicates the claim and Coastal Cardiology receives an explanation of benefits. Any underpayment will be billed accordingly.

SELF-PAY SERVICES

Services provided to self-pay patients, those not using insurance, will be paid in full at the time of service, before the service is performed.

WORKER'S COMPENSATION

Coastal Cardiology is not a worker's compensation provider. Please be aware patients maintain full financial responsibility for the care provided regardless of worker's compensation status.

BALANCES & REFUNDS

Please note all balances are due within thirty (30) days. After thirty (30) days, unpaid balances are considered past due. After sixty (60) days, collection proceedings will begin. At the doctor's discretion, due to the time and expense of collection proceedings, patients sent to collections may be discharged from the practice. Similarly, overpayments of $20 or more are refunded within sixty (60) days. Less than $20 will be held and applied to future balances unless a refund is requested by the patient, in which case it will be refunded within sixty (60) days.

FINANCIAL HARDSHIP

We recognize extraordinary circumstances can and do occur. In such situations, signed payment arrangements may be made. However, payment agreements do not exceed ninety (90) days without express authorization.

Any alternate arrangements must be made in advance of the service. Please communicate freely with your physician and Coastal Cardiology's Business Office staff when they contact you to avoid possible rescheduling of appointments, tests or procedures.

Additional inquiries may be directed to the Coastal Cardiology Business Office at 805/540-5865.

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Pre-Appointment Medical Records Release

1941 Johnson Avenue Suite 101 San Luis Obispo, CA 93401
805-782-8844 x508 phone 805-782-8859 fax

Instructions: Any facility that has records will need to receive a completed, signed records release. Please fill in the blanks below and send one to each facility. You may also return completed forms to Coastal Cardiology and we will send them on your behalf.

To: _____
_____
_____

I have an appointment at Coastal Cardiology on _____ that requires medical records. Please send the following records in a timely manner:

☐ Cardiology records ☐ Recent Labs
☐ Hospitalizations ☐ Other records relevant to cardiac consultation

Send To: Coastal Cardiology Attn: Medical Records
1941 Johnson Ave Ste 101 San Luis Obispo, CA 93401
OR fax them to 805/782-8859

My information is

- Name: _____
- Date of Birth: _____ Account # (if known): _____
- Phone: _____

I understand this information may be shared in paper or electronic format, may include documentation of alcohol abuse, psychiatric conditions, drug abuse or communicable disease (☐ check here to request the exclusion of all confidential information), this authorization expires one (1) year after it is signed, a copy of this authorization is as a valid as the original and I have a right to a copy of this document.

➲_____
Patient/Personal Representative's Signature **Date**

➲If you are not the patient, documentation of your signatory authority is needed.
Print your name _____ and indicate your relationship:
☐ Parent/Guardian ☐ Beneficiary/Conservator/Representative ☐ Other: _____.

This release is in 14-point font per Cal Civ Code §56.11.