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 #:

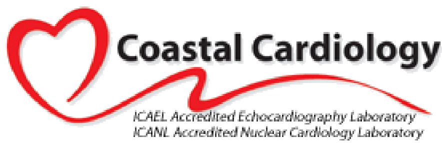
INFORMATION

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:		



Patient Registration Form

Coastal Cardiology's physicians and advanced practice providers 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 consent to services such as televisits, cardiac device checks, anticoagulant management, and inter-professional consultations done remotely and related insurance claims until my written revocation.

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 acknowledge Coastal Cardiology cares for critical conditions which may require short notice changes to attend to emergencies. I understand my care would receive the same attention in an urgent situation and am aware sudden rescheduling will occur only when needed. I understand Coastal Cardiology staff are to be treated respectfully without verbal harassment, foul language, or intimidation. I am aware Coastal Cardiology staff reserve the right to dismiss patients from the practice if there are communications below the expected standard of civility.

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: ____________