

Coastal Pulmonary Associates

(Please Print)							PATIENT REGISTRATION		
PATIENT NAME		(LAST)		(FIRST)		(MIDDLE)			
HOME ADDRESS			CITY		STATE		ZIP		HOME PHONE
SOCIAL SECURITY NUMBER			DATE OF BIRTH	AGE	SEX	MARITAL STATUS		CELL PHONE	
EMPLOYER			OCCUPATION			M S D W		WORK PHONE	
REFERRING PHYSICIAN (NAME, ADDRESS, PHONE)					PRIMARY CARE PHYSICIAN				

EMERGENCY CONTACT INFORMATION			
NAME		RELATIONSHIP TO PATIENT	PHONE
ADDRESS		CITY	ZIP

PRIMARY INSURANCE INFORMATION				
INSURANCE COMPANY			PHONE NUMBER	
INSURANCE COMPANY ADDRESS				
SUBSCRIBER'S NAME		DATE OF BIRTH	SUBSCRIBER'S SS#	RELATIONSHIP TO PATIENT
GROUP NUMBER		ID OR POLICY NUMBER		EFFECTIVE DATE

SECONDARY INSURANCE INFORMATION			
INSURANCE COMPANY			
INSURANCE COMPANY ADDRESS			
SUBSCRIBER'S NAME		SUBSCRIBER'S SS#	RELATIONSHIP TO PATIENT
GROUP NUMBER		ID OR POLICY NUMBER	EFFECTIVE DATE

WORK RELATED INJURIES ONLY / COMPLETE THE FOLLOWING			
COMPENSATION INSURANCE CARRIER			
INSURANCE COMPANY ADDRESS		PHONE NUMBER	COMPANY PHONE NUMBER
DATE OF INJURY	WAS INJURY REPORT FILED?	NAME OF INSURANCE ADJUSTER	ADJUSTER PHONE NUMBER

PLEASE READ CAREFULLY

In order to provide you with the highest quality of affordable healthcare, we request that our charges for office visits be paid at the conclusion of each visit. 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, others pay a percentage of the charge. It is your responsibility to pay any co-insurance, or any other balance not paid for by your insurance. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection, to the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of the patient's record. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to the provider. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all necessary information to secure payment. Coastal Pulmonary Associates and/or physicians may have a financial or other interest in companies which manufacture or distribute some of the products that are used in the course of your treatment. If you have questions or concerns about a particular product or manufacturer, please let your physician know.

Signature (Responsible Party): _____ Date: ____ / ____ / ____ Acct# _____

Coastal Pulmonary Associates

Patient's name: _____

Date: _____

Referring doctor: _____

Reason for visit/current pulmonary symptoms: _____

Length of time experiencing symptoms: _____ months, _____ years.

Which treatments have been tried? Medications/testing _____ Location: _____

Allergies

Do you have any known drug, food, or environmental allergies?	Yes	No
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Please list any allergies below:

Current Medications

List any medications you are taking, including over-the-counter medications and supplements:

Medication	Dose	How Often

Past Medical History

Do you have or have you had any of the following medical conditions?

	Yes	No
Hypertension (high blood pressure)		
Heart disease		
Stroke		
Diabetes		
Asthma		
Emphysema		
Peptic ulcers (stomach or duodenal)		
Kidney disease		
Hepatitis		
Cancer		
Thyroid disease		
Osteoporosis		
Arthritis		

Family History

Have any of your blood relatives (living or deceased) had any of the following conditions?

	Yes	No
Hypertension (high blood pressure)		
Heart disease		
Stroke		
Diabetes		
Asthma		
Emphysema		
Peptic ulcers (stomach or duodenal)		
Kidney disease		
Hepatitis		
Cancer		
Thyroid disease		
Osteoporosis		
Arthritis		

List other medical conditions you have below:

Social History

Which best describes your situation?

I live alone	
I live with family	
I live with friends	
I live in a structured setting with help	

OB GYN for Women

Are you pregnant now?	Yes	No
How many children have you had?		
	0	1
	2	3
	4	5
	6+	

What is your smoking history?

I have never smoked	
I used to smoke	
I currently smoke	
How many packs per day?	

What is your alcohol intake?

I do not drink alcohol	
I drink alcohol rarely	
I drink alcohol daily	
I drink once or more per week	
I drink once or more per month	

Past surgical History

Please list the surgical procedures you have had and your approximate age at the time.

Procedure	Age

Review of Systems

Which of the following have you had?

Skin/Lymphatic

Rash	Yes	No
New skin spots	Yes	No
Skin infections	Yes	No
Change in a mole	Yes	No
Non-healing sores	Yes	No
Swollen lymph nodes	Yes	No

Neurologic

Severe headaches	Yes	No
Fainting spells	Yes	No
Seizures and convulsions	Yes	No
Dizziness	Yes	No
Memory loss	Yes	No

Eyes

Vision problems	Yes	No
Glaucoma	Yes	No

ENT

Hoarseness	Yes	No
Nose bleeds	Yes	No
Hearing loss	Yes	No
Ringing in the ears	Yes	No
Difficulty swallowing	Yes	No
Tooth pain or infection	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid disease	Yes	No

Urologic

Burning with urination	Yes	No
Blood in urine	Yes	No
Frequency of urination	Yes	No

Allergies/Immune Disorders

Hay fever	Yes	No
Anaphylactic reaction	Yes	No
Rheumatoid disease	Yes	No
Other autoimmune disease	Yes	No

Gastrointestinal

Heartburn	Yes	No
Abdominal pain	Yes	No
Nausea	Yes	No
Jaundice	Yes	No
Bloody stool	Yes	No
Black stool	Yes	No

Musculoskeletal

Joint pain	Yes	No
Joint swelling	Yes	No
Back pain	Yes	No
Neck pain	Yes	No
Muscle pain	Yes	No

Hematologic

Easy bruising	Yes	No
Excessive bleeding	Yes	No

Constitutional

Chronic fatigue	Yes	No
Weight loss	Yes	No
Excessive weight gain	Yes	No
Fever	Yes	No
Night sweats	Yes	No

Cardiovascular

Chest pain	Yes	No
Racing heart beat	Yes	No
Poor circulation	Yes	No

Psychological

Depression	Yes	No
Anxiety	Yes	No

Respiratory

Asthma	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
Persistent cough	Yes	No
Cough up blood	Yes	No

Coastal Pulmonary Associates

Medical Records Request

I hereby authorize:

Dr./Group Name: _____

Address: _____

Phone: _____ Fax: _____

To furnish copies of my records listed below to
Coastal Pulmonary Associates
320 Santa Fe Drive, Suite 107-C
Encinitas, CA 92024

Or fax to 760-944-1309

X-Rays/Imaging

X-Ray/Imaging Reports

Laboratory Data

History and Physical Reports

Operative Reports

Pathology Report

Visit Notes

ALL RECORDS

Date: _____ Patient's Signature: _____

Birth Date: _____ Patient's Name: _____

This notice describes how health information about our patients may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use And Disclosure Of Your Health Information In Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities/health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.
9. Data that is collected by Coastal Pulmonary Associates, which does not include the identity of the patient, may be utilized for research purposes.

Your Rights Regarding Your Health Information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests. -
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Coastal Pulmonary Associates who will have up to 30 days to comply.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Coastal Pulmonary Associates who will have 60 days to respond. You must provide us with a legitimate reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy of this notice by contacting our front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint, contact Coastal Pulmonary Associates at (760) 230-8994. All complaints must be submitted in writing; you will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your physician. I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

General Authorization to Release Health Information

I hereby authorize the release of my personal health information to any health provider approved by my treating physician. I understand that I may cancel this authorization at anytime by notifying my treating physician in writing.

Signature: _____ Date: _____

Print Name: _____