Coastal Pulmonary Associates

(Please Print) PATIENT REGISTRATION

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

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP TO PATIENT	PHONE	
ADDRESS	CITY	STATE	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	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 maunfacturer, please let your physician know.

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

New Patient [ ] Update [ ]

320 SANTA FE DRIVE SUITE 107-B, ENCINITAS, CA 92024
PHONE: (760)230-8994 FAX: (760)944-1309
www.coastalpulmonary.com

Past
Medical
History

Coastal Pulmonary Associates

Patient's name:_____ Date:_____

Allergies

Do you have any known drug, food, or environmental allergies?	Yes	No

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

Family History

Have any of your blood relatives (living or deceased) had any of the following conditions?		
Hypertension (high blood pressure)	Yes	No
Heart disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Peptic ulcers (stomach or duodenal)	Yes	No
Kidney disease	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
Thyroid disease	Yes	No
Osteoporosis	Yes	No
Arthritis	Yes	No

List other medical conditons 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 now pregnant?	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 a day?	

Past Surgical Procedures

List any surgical procedures you may have had in the past and your approximate age at the time:	
Procedure	**Age**

What is your alcohol intake?	
I do not drink alcohol	
I drink alcohol every day	
I drink once or more each week	
I drink once or more each month	
I drink rarely	

Continue on the back side

REVIEW OF SYSTEMS

Which of the following do you have?

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
Persistant cough	Yes	No
Cough up blood	Yes	No

For Office Use:

Physician notes:

Patient Update

Date of Visit	Changes (Y/N)	Initials

Physician Review Dates

Date of Visit	Physician Signature

Coastal Pulmonary Associates

Notice of Privacy Practices

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 (HIPPA).

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:_____

Coastal Pulmonary Associates

320 Santa Fe Drive Ste 107-B Encinitas, CA 92024 • Ph:760-230-8994 Fax: 760-944-1309

Authorization for Release of Information to Family Members

Patient Name_____Date of Birth_____.

Many of our patients allow family members such as their spouse, parents, or others to call and request medical information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only allow us to give information to the family members listed below.

I authorize Coastal Pulmonary Associates to release my medical and/or billing information to the following individual(s):

1._____Relationship to Patient:_____.

2._____Relationship to Patient:_____.

3._____Relationship to Patient:_____.

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any of the above recipient(s) is no longer protected by federal or state law and may use subject redisclosure by the above recipient(s).

You have the right to revoke this consent in writing.

Signature:_____Date:_____.

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-B
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:_____