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		
PREFERRED PHARMACY (NAME, ADDRESS AND PHONE)				
REFERRING PHYSICIAN (NAME AND PHONE)	PRIMARY CARE PHYSICIAN (NAME AND PHONE)			

EMERGENCY CONTACT INFORMATION			
NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER	
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	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	

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:_____/_____/_____

326 Santa Fe Drive, Suite 100 • Encinitas, CA 92024
2067 W. Vista Way, Suite 160 • Vista, CA 92083
Tel: (760) 230-8994 • Fax: (760) 944-1309

Coastal Pulmonary Associates

HEALTH QUESTIONAIRE

Patient's name:_____ Date:_____

ALLERGIES

Do you have any known drug, food, or environmental allergies?	YES	NO

PLEASE LIST ANY KNOWN 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	**YEAR**

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	

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

Authorization for Release of Information

Patient Name_____Date of Birth_____

Many of our patients allow family members such as their spouse, parents, and children over the age of 18, or others to call and request medical information. Under the requirements of HIPAA we are not allowed to give this information to anyone without patient consent, including but not limited to: scheduling/confirming/cancelling appointments, requesting or picking up prescriptions, requesting or picking up records or results etc.

If you wish to have your medical, or billing information discussed or released to family members, you must sign this form. Signing this form will only allow us to give information to the individuals 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. If I wish to revoke this authorization, I need to submit a written request to do so. I have the right, upon request, 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 Coastal Pulmonary Associates, federal or state law, as they cannot guarantee what the individuals I authorized as recipients, will do with my information.

Patient's Signature:_____ Today's Date:_____

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Coastal PULMONARY ASSOCIATES

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Medical Records Request

I hereby authorize **Coastal Pulmonary Associates to obtain** copies of my records from the entity listed below:

Doctor/Group Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Records Requested:

___ X-Rays/Imaging

___ X-Ray/Imaging Reports

___ Laboratory Data

___ History and Physical Reports

___ Operative Reports

___ Pathology Report

___ Visit Notes

___ ALL RECORDS from _____ to _____

___ ALL Existing records

Patient's Name: _____ Birth Date: _____

Patient's Signature: _____ Today's Date: _____

Please fax or mail records to contact listed below as soon as possible. Thank you.

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