



PATIENT REGISTRATION INFORMATION PACKET

BRING THIS COMPLETED PACKET ON THE DAY OF YOUR APPOINTMENT. DO NOT MAIL OR FAX THIS IN.

PLEASE PRINT USING BLACK INK ONLY.

1. PATIENT DEMOGRAPHICS

DATE	HOME PHONE	CELL PHONE
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PATIENT LAST NAME	FIRST NAME	INITIAL
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RESPONSIBLE PARTY (IF A MINOR)

STREET ADDRESS

CITY	STATE	ZIP
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SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE	BIRTH DATE	LAST 4 DIGITS OF SSN #
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MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/> Retired
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EMAIL ADDRESS

PATIENT EMPLOYED BY	BUSINESS PHONE
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BUSINESS ADDRESS	OCCUPATION
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2. INSURANCE INFORMATION (REQUIRED COMPLETELY)

PRIMARY INSURANCE

NAME OF INSURER & RELATIONSHIP	MEMBER ID	GROUP NUMBER
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SECONDARY INSURANCE

NAME OF INSURER & RELATIONSHIP	MEMBER ID	GROUP NUMBER
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CONDITION & ACCIDENT PROFILE

IS YOUR CONDITION RELATED TO EMPLOYMENT? (CURRENT OR PREVIOUS)

Yes No

IS YOUR CONDITION RELATED TO AN AUTO ACCIDENT?

Yes No

STATE WHERE ACCIDENT OCCURRED:

OTHER ACCIDENT?

Yes No

PRIMARY OR REFERRING DOCTOR NAME (GENERAL PRACTITIONER, SPECIALIST, OR OTHER)	WHOM MAY WE THANK FOR REFERRING YOU?
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REASON FOR CARDIOLOGY VISIT

3. AUTHORIZATIONS & RELEASES

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ (Name of Insurance Company) _____ and assign directly to Premier Cardiology, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

 SIGNATURE OF INSURED / GUARDIAN DATE

MEDICARE AUTHORIZATION (IF APPLICABLE)

I request that payment of Medicare benefits are made on my behalf to Premier Cardiology, for any services furnished to me by their physician's. I authorize Premier Cardiology to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claim, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

 PATIENT SIGNATURE DATE

PATIENT MEDICAL QUESTIONNAIRE

PATIENT NAME	TODAY'S DATE	PRIMARY PHYSICIAN
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CURRENT PROBLEMS / CHIEF COMPLAINTS

PLEASE LIST ANY ALLERGIES

CORONARY ARTERY DISEASE RISK PROFILE

SMOKING HISTORY

Have you ever smoked? No (skip to next section) Yes

HOW MANY YEARS SMOKED? _____ AT WHAT AGE DID YOU START? _____ AVERAGE PACKS PER DAY _____

Do you still smoke? Yes No AT WHAT AGE DID YOU STOP? _____

HIGH BLOOD PRESSURE HISTORY

Has your blood pressure ever been high? No (skip to next section) Yes

Have you ever been treated for high blood pressure? Yes No HOW MANY YEARS? _____

Are you taking medicines now for high blood pressure? Yes No

FAMILY HISTORY OF CORONARY DISEASE

Is there coronary disease in your family? (angina, heart attack, angioplasty or bypass)? Yes No

RELATIVE	AGE STARTED	PROBLEM(S)

OTHER HEALTH COMPLAINTS: REVIEW OF SYMPTOMS

PLEASE CHECK IF YOU HAVE MAJOR PROBLEMS WITH THESE SYMPTOMS:

<p>GENERAL</p> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> appetite changes <input type="checkbox"/> chills <input type="checkbox"/> fever <input type="checkbox"/> lethargy <input type="checkbox"/> night sweats <input type="checkbox"/> weight gain <input type="checkbox"/> weight loss <p>GASTROINTESTINAL</p> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> abdominal pain <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> vomiting <input type="checkbox"/> nausea <input type="checkbox"/> black stool <input type="checkbox"/> bloody vomit <input type="checkbox"/> blood stool 	<p>CARDIOVASCULAR</p> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> chest pain <input type="checkbox"/> chest pressure <input type="checkbox"/> increased fatigue <input type="checkbox"/> breathing flat problems <input type="checkbox"/> palpitations <input type="checkbox"/> passing out <input type="checkbox"/> lightheadedness <input type="checkbox"/> edema (general) <input type="checkbox"/> leg swelling <p>RESPIRATORY</p> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> cough <input type="checkbox"/> wheezing <input type="checkbox"/> pain with breathing <p>EYES</p> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> discharge (eyes) <input type="checkbox"/> eye pain <input type="checkbox"/> vision loss <input type="checkbox"/> visual changes 	<p>NEUROLOGICAL</p> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> difficulty walking (gait) <input type="checkbox"/> headache <input type="checkbox"/> limb (muscle) weakness <input type="checkbox"/> numbness in extremities <input type="checkbox"/> speech difficulty/changes <input type="checkbox"/> seizures <input type="checkbox"/> tremors <p>MUSCULOSKELETAL</p> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> bone pain <input type="checkbox"/> joint pain <input type="checkbox"/> muscle cramps <input type="checkbox"/> knee problems <input type="checkbox"/> muscle spasms <p>PSYCHIATRIC</p> <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> anxiety <input type="checkbox"/> depression
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4. PAST MEDICAL HISTORY

PLEASE CIRCLE ANY MEDICAL PROBLEMS YOU HAVE OR HAVE HAD:

Abdominal aortic aneurysm • Alcoholism • Alzheimer's disease • Anemia • Anxiety • Arthritis • Asthma
• Atrial fibrillation • Benign prostatic hypertrophy • Chronic renal failure • Congestive heart failure •
Coronary artery disease • Depression • Diabetes • Gastroesophageal reflux disorder • High blood
pressure • Hyperlipidemia • Myocardial infarction • Obesity • Parkinson's disease • Paroxysmal
supraventricular tachycardia • Peptic ulcer disease • Premature ventricular contractions • Stroke •
Ulcerative colitis

CANCER (WRITE TYPE IF CIRCLED ABOVE):

5. SURGICAL HISTORY

PLEASE CIRCLE ANY SURGICAL PROCEDURES YOU HAVE HAD:

Appendectomy • Tonsillectomy • Mastectomy (total or partial) • Breast implantation • Coronary artery
bypass graft surgery • Pacemaker • Hysterectomy • Prostate surgery • Mitral valve repair • Mitral valve
replacement • Aortic valve replacement • Gallbladder removal

OTHER SURGERIES NOT LISTED ABOVE:

6. CURRENT MEDICATIONS & PHARMACY INFORMATION

LIST YOUR CURRENT MEDICATIONS & DOSAGES (PER DAY AND STRENGTH):

(Example: Tylenol - 500 mg twice a day / morning and evening)

#	MEDICATION NAME	STRENGTH	DOSAGE / FREQUENCY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

(For additional medications please use reverse side)

MY SIGNATURE BELOW AUTHORIZES PREMIER CARDIOLOGY TO OBTAIN EXTERNAL RX HISTORY

SIGNATURE

DATE

PHARMACY INFORMATION

PHARMACY NAME	PHARMACY PHONE NUMBER
PHARMACY ADDRESS	PHARMACY FAX NUMBER (IF KNOWN)

OFFICE & FINANCIAL POLICIES

OVERVIEW OF FINANCIAL RESPONSIBILITIES

Practice Responsibilities: To submit claims to insurance, and statements to the patient/responsible party based on the information made available to us. To provide patients with the network and billing information that is available to us.

Patient/Parent/Guardian Responsibilities: To understand their own insurance network and benefits. To assure that our office is provided with the most current information known about their insurance, and to inform us of any changes in insurance or demographics (address, phone numbers, etc). To pay within 30 days any balance shown as patient responsibility (e.g., co-pay, deductible, and co-insurance).

PATIENT NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH	INSURANCE SUBSCRIBER NAME (IF NOT PATIENT)	RELATIONSHIP

DETAILED POLICIES

Patient must understand their OWN network, plan benefits, and plan limitations. Your health insurance is an agreement between you and your insurance. All charges are ultimately your responsibility, whether you have insurance or not. Not all services are covered under all plans, regardless of whether our doctors consider the care medically necessary. By presenting a copy of your card, it does not confirm that we are part of your Network. Ultimately, it is your responsibility for payment of services rendered. We are in network with most traditional PPO plans and with one HMO (Hoag Medical Grp/HPP): We are not contracted with Medicaid/ Medi-Cal/CalOptima & Worker's Compensation plans. Our recommendation is to call your insurance before your appointment and ask if your plan's network includes our office, and what patient cost sharing may be applied. You authorize your insurance to pay us directly.

INITIAL HERE

Bring patient's Insurance Card to every visit. Patients with insurance are responsible for ensuring that our insurance records and other information are up to date. Patients who have not presented a valid active insurance card will be considered self-pay/cash-pay and they must pay our self-pay visit fee at arrival. Patients will have full responsibility for charges if we cannot process a claim due to incomplete, inaccurate or obsolete information. If your insurance changes, you must notify us immediately; delays can result in the claim being uncollectible from insurance, resulting in patient having full responsibility for all charges.

INITIAL HERE

Co-Pay & Self-Pay services are due at the time of Service. Co-Pay is always expected at date of service. There is a \$5 billing fee for all Co-Payments that must be billed after the date of service.

INITIAL HERE

Bills are DUE UPON RECEIPT. We are required to collect CO-PAY, DEDUCTIBLE, AND CO-INSURANCE. Past due balances will be assessed a \ \$10 statement fee for each additional statement we must send. We may charge 18% interest or as allowed by law for any delinquent payment. We exhaust efforts to resolve balances prior to use of a collection agency, however, additional fees up to 50% of your charges may accrue from collections activity. Returned checks will be assessed \ \$25 fee.

INITIAL HERE

Appointment Cancellation Fees. We make numerous efforts to remind you of appointments. Please notify us if you need to cancel at least one full business day prior. The following fees will apply for late cancellation or no shows: \ \$25 for a regular appointment or office test. Exception: the late cancel/no show fee is \ \$250 for a nuclear study appointment.

INITIAL HERE

Your health information is protected. We must release patient health information to complete medical operations (e.g., to pharmacies, labs, insurance, other physicians, etc.) Any other release requires your written consent. Our Notice of Privacy Practices is available to you. We will only leave a detailed message on your home phone or cell phone with your authorization (see separate sheet).

INITIAL HERE

The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. Patients are welcome to review it at <https://openpaymentsdata.cms.gov>

INITIAL HERE

AGREEMENT BY PATIENT (OR PARENT OR GUARDIAN)

I HAVE READ EACH POLICY. I UNDERSTAND THEM, AND I AGREE.

SIGNATURE OF PATIENT (OR PARENT OR GUARDIAN) _____
DATE

PRINTED NAME OF PATIENT (OR PARENT/GUARDIAN)	DATE OF BIRTH	LAST 4 OF SS NUMBER
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STREET ADDRESS (STREET, CITY, STATE, ZIP)

PREFERRED PHONE NUMBER <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other	EMAIL
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**Thank you for taking the time to understand our Office Policies. Please contact our office with any questions.
(949) 478-7373**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME

PATIENT DATE OF BIRTH

I AUTHORIZE THE FOLLOWING TO HAVE ACCESS TO MY MEDICAL RECORDS (CHECK ALL THAT APPLY): My Spouse Name: _____ My Child Name: _____ My Representative Name: _____ Other Person Name & Relationship: _____

I also give permission for my physician to give test results and discuss my medical condition with the above named person/persons:

 Yes No *(Check One)*

I authorize Premier Cardiology, Inc. doctors or personnel to leave messages regarding test results on my home answering machine and my cell phone:

 Yes No *(Check One)*_____
PATIENT SIGNATURE_____
DATE SIGNED

The doctors and staff of Premier Cardiology, Inc. will follow the directions indicated above until notified in writing of any change(s).

PATIENT PORTAL ENROLLMENT

What is the portal?

The patient portal (Healow) is an email type of communication service available to our patients that allows for secure communication between you and your doctor and his staff. You can use the portal to ask questions of your doctor and his staff, request prescription refills, inquire about test results, request appointments, and more.

Is it safe?

Yes. You can be sure that communication via the internet is safe because it is password protected.

How do I get started?

When we have signed you up, the portal will send you an email to the email address you provide. Open the email and follow the instructions to complete your registration.

***** PLEASE ENTER YOUR EMAIL ADDRESS HERE *****

PATIENT PORTAL EMERGENCY POLICY

Our physicians utilize an online patient portal for the convenience of our patients. The portal allows patients to email our doctors and medical assistants for **NON URGENT** questions regarding their care.

Your signature below signifies you understand and agree that for any urgent or emergent issues you will contact your physician by phone. If for some reason you cannot reach the physician (or medical assistant during office hours), and your matter is urgent or emergent, you agree to contact the nearest hospital or urgent care center. Thank you for your understanding.

PATIENT PRINTED NAME

PATIENT SIGNATURE

DATE SIGNED