Coastal Comprehensive Care
Internal Medicine
25226 Cabot Road
Laguna Hills, CA 92653

PATIENT INFORMATION REGISTRATION

First name:_____ Last name:_____ MI:____

Preferred name:_____ Date of Birth:_____

Sex: ☐ Male ☐ Female Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

SSN#:_____ Address:_____

Address 2:_____ City:_____ State:_____ Zip:_____

Cell phone:_____ Home phone:_____

Email address:_____

How did you hear about us (ie website, referral, etc.) :_____

Preferred pharmacy:_____

Parent/Guardian of Minor (with patient today):

First name:_____ Last name:_____ MI:____

Relationship:_____ Phone:_____ SSN#_____

Address (if different from above):

Street:_____ City:_____ State:_____ Zip:_____

Primary Insured Information:

First name:_____ Last name:_____ MI:____

Relationship:_____ Date of Birth:_____ SSN#_____

Address (if different from above):

Street:_____ City:_____ State:_____ Zip:_____

Insurance Carrier:_____ Employer:_____

ID#:_____ Group#:_____ Work phone:_____

Secondary insurance?_____

Emergency contact:

Name:_____ Relation:_____ Phone#:_____

Assignment of benefits: I directly assign all medical/surgical benefits to Coastal Comprehensive Care and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure payment of health benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Consent to examine and treat: I give my consent for examination and treatment of myself and all minor children listed above.

Signature:_____ Date:_____

MEDICAL HISTORY

History & Physical Form

Complete both sides of this form. If a section does not apply to you, please address it with an *N/A*, so we don't assume you've overlooked it.

Patient Name:_____ Date:____/____/____
Please Print Last First MI

List your ***Main Complaint(s)***:_____
Describe your condition *(i.e. onset, cause, etc.)*

_____

_____

List the date & type of diagnostic procedures (i.e. MRI's, C/T Scans, X-ray's etc.) you've had, which pertain to the condition you're being evaluated for today:

_____

Medical History & Review of Systems

Do you or have you had any of the following?
Transmissible Disease(s): ☐ *None* ☐ Hepatitis A-B-C ☐ HIV ☐ TB ☐
Other_____
Neurological: ☐ Headaches ☐ Stroke ☐ Epilepsy ☐ Aneurysm ☐
Other_____
Cardiovascular: ☐ Chest Pain ☐ High Blood Press. ☐ Heart Disease ☐
Other_____
Respiratory: ☐ Lung Disease ☐ Asthma ☐ Shortness of Breath ☐
Other_____
Are you a smoker? ☐ No ☐ Yes # of years_____ # of packs per day_____
Gastrointestinal/Adb. & Pelvis: ☐ Ulcer ☐ Hernia ☐ Hysterectomy ☐
Other_____
Musculoskeletal: ☐ MSD ☐ Arthritis ☐ Back or Neck Pain ☐
Other_____
Metabolic: ☐ Liver Disease ☐ Thyroid Disorder ☐ Bleeding Disorder ☐ Cancer ☐ Diabetes ___
Meds.___Insulin
☐ Other_____ *check one*
Genito-Urinary: ☐ Kidney Disease ☐ Painful Urination ☐ Freq. Urination ☐ Poss. Pregnancy ☐
Sexual Dysfunction
Eye Problems: ☐ Blindness ☐ Cataracts ☐ Glaucoma ☐ Vision Difficulty
E.N.T.: ☐ Hearing Loss ☐ Deaf ☐ Swallowing Problems ☐ Nose Bleeds
Psychological: ☐ Anxiety ☐ Depression ☐ Fatigue ☐ Nervousness
☐Other_____

Previous Hospitalizations/Surgeries (List Type and Year)

1._____ 2._____

3._____ 4._____

5._____ 6._____

☐ See Attached

Medications you are currently taking:

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

☐ See Attached

List Allergies:

1._____ 2._____

3._____ 4._____

5._____ 6._____

☐ See Attached

List Your Employer:_____Hrs. worked per week _____

Duties:_____

Patient Social History

1.Use of Alcohol_____Never _____ Rarely_____Moderate _____ Daily

2.Use of Drugs ☐ Opiates ☐ Benzodiazepines ☐Tobacco ☐ Amphetamines ☐ Other _____

3.Sleep Habits_____

4.Exercise Habits_____

5. Diet _____

6.Sexually Related Complaints_____

7.Leisure (Hobbies)_____

8. Stress Level _____

Family Medical History

	AGE	DISEASES	IF DECEASED , CAUSED DEATH
FATHER			
MOTHER			
SIBILINGS			
SPOUSE			
CHILDREN			

Office Financial Agreement

The following describes our financial policy. All patients are ultimately responsible for payment of all charges and must sign this AGREEMENT, a copy of which will be kept in your file record.

HEALTH INSURANCE

We will bill MEDICARE and your PPO Health Plan (if we are contracted with them) as a courtesy if you present:

- A valid, current insurance card
- Valid identification
- Payment of **co-payment** when checking into the office, **co-insurance** when leaving the office, and/or unmet deductible.
- Your co-payment applies toward the office visit **only.** All other services may have an additional co-payment which is determined at the time your claim is processed.
- Verification of insurance coverage **is not** a guarantee of payment. The patient is responsible for all denied charges. Any insurance disputes are between the patient and their insurance carrier.
- Our office does not accept insurance only as payment in full and cannot make adjustments to your account if charges are applied towards your deductible.
- **The patient's insurance coverage is a contract between the patient and their insurance carrier NOT a contract between Coastal Comprehensive Care and the insurance carrier. It is the patient's responsibility to understand their insurance coverage, all policy limitations and preferred providers under their policy.**
- **Coastal Comprehensive Care employees are not responsible for providing the patient with an explanation of their coverage, co-payments, deductibles or pre-existing conditions. Please note: Any service provided under EPO coverage will be considered out-of-network unless otherwise advised by the patient's insurance carriers.**

CASH PATIENTS

Cash patients must pay, in full, at the time of service. We accept cash, check, VISA, Mastercard, American Express, and Discover.

PAYMENT RESPONSIBILITY

If insurance payment is not received in full within 45 days of the date of service, the patient is responsible for payment. We will bill this to a credit card of your choice (See below). In the following circumstances we require payments in full at the time of service:

- Whenever we are unable to verify insurance eligibility.
- If you are involved in an auto accident.
- If you have out of state insurance that we are not contracted with.

REFUNDS

Any overpayment will be refunded within 30 days of the insurance payment; however if there is an outstanding balance the overpayment will be applied.

RETURNED CHECKS

There will be a $35 fee for returned checks.

I have read the above AGREEMENT and understand and agree to its terms. I also authorize Coastal Comprehensive Care to furnish information to insurance carriers concerning my treatment and I hereby assign all payment for services rendered.

Patient/Guardian Signature:_____ Date: _____

Credit Card #:_____ Exp Date:_____

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Coastal Care Internal Medicine may use and disclose protected health information about you to carry out Treatment, Payment and Health Care Operations. Please refer to our Notice of Privacy Practice for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 25226 Cabot Rd, Laguna Hills, CA 92563.

With your consent, Coastal Care Internal Medicine may call your home or office and leave a message in reference to any items that assist the practice in carrying out Treatment, Payment, and Health Care Operations such as appointment reminders, insurance items and any call pertaining to clinical care.

With your consent, Coastal Care Internal Medicine may mail to your home or office any items that assist the practice in carrying out Treatment, Payment and Health Care Operations, such as appointment reminder cards and patient statements.

I give my consent to electronically send or fax my records for the purpose of Treatment, Payment, or Health Care Operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third party. In the event that this should occur, I absolve, Coastal Care Internal Medicine of all liability.

You have the right to request that we restrict how we use or disclose your protected health information to carry out Treatment, Payment, and Health Care Operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your protected health information to carry out Treatment, Payment, and Health Care Operations. This consent may be revoked in writing except to the extent that we have already made our disclosures in reliance upon your prior consent. **If you decline to sign this consent, we may decline to provide treatment for you.**

Signature of Patient or Legal Guardian_____Date_____

This authorization Will Remain Standing Until Revoked in Writing.

Patient's Name_____Date of Birth_____

Print Name of Patient or Legal Guardian_____ Date_____

ONLY SIGN BELOW IF YOU ARE DECLINING THIS CONSENT

I, _____, decline to the use and disclosure of my protected health information to carry out treatment, payment, and health care operations.