# Saddleback Pulmonary Associates and Coast Medical Group

*Pulmonary Medicine, Critical Care, Sleep Disorders, Internal Medicine, and Cardiology*

## PATIENT INFORMATION QUESTIONNAIRE (All information Confidential)

**PATIENT:**

Patient Name_______________________________________________
Last First MI

Patient Address_______________________________________________

City, State_______________________________________________

Zip Code_______________________________________________

Home Phone_______________________________________________

Business Phone_______________________________________________

Email Address_______________________________________________

Employer_______________________________________________

Occupation_______________________________________________

Birth date________________________Age _______________

Social Security # (last 4 digits)_________________________________

Sex______________ Marital Status ________

**RESPONSIBLE PARTY (if different) or Spouse Info.**

Resp. Party_______________________________________________
or Spouse Last First MI

Address_______________________________________________

City, State _______________________________________________

Zip Code _______________________________________________

Home Phone_______________________________________________

Business Phone_______________________________________________

Email Address_______________________________________________

Employer_______________________________________________

Occupation_______________________________________________

Birth date__________________________Age _____________________

Social Security # (last 4 digits) ___________________________________

Family Physician _______________________________________________

In Emergency Contact (Name & Phone Number)_______________________________________________

INSURANCE COMPANY INFORMATION

**PRIMARY INSURANCE**

Insurance Co._______________________________________________

ID# _______________________________________________

Group # _______________________________________________

**SECONDARY INSURANCE**

_______________________________________________

_______________________________________________

_______________________________________________

**WORKER'S COMPENSATION CLAIMS**

Insurance Co._________________________________________

Claim # _________________________________________

Date of Accident/Injury___________ ______________________________

Policy #_______________________________________________

Contact Person/Adjuster_________________________________________________Telephone # _________________ _____________________

## AUTHORIZATION FOR RELEASE OF INFORMATION AND INSURANCE ASSIGNMENT

I hereby authorize assignment and payment directly to Saddleback Pulmonary Associates, and/or Coast Medical Group., all Insurance 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 authorize the use of my signature on all insurance submissions.

Saddleback Pulmonary Associates and/or Coast Medical Group., may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I request that payment of authorized Medicare benefits and, if applicable, MediCAL benefits be made on my behalf to Saddleback Pulmonary Associates and/or Coast Medical Group

I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

I AUTHORIZE THE PHYSICIANS, EMPLOYEES OR ASSOCIATES OF SADDLEBACK PULMONARY ASOCIATES AND/OR COAST MEDICAL GROUP TO OBTAIN ANY MEDICAL INFORMATION THEY MAY NEED TO PARTICIPATE IN MY MEDICAL CARE.

I AUTHORIZE THE PHYSICIANS OF SADDLEBACK PULMONARY ASSOICATES AND/OR COAST MEDICAL GROUP TO RELEASE INFORMATION, INCLUDING FAXED INFORMATION, TO ANY PERSON PARTICIPATING IN MY MEDICAL CARE. I RELEASE SHAHINIAN PULMONARY ASSOCIATES FROM ANY LIABILITY IN THE EVENT THAT UNAUTHROIZED INDIVIDUALS RECEIVED MEDICAL INFORMATION NOT INTENDED FOR THEIR USE THROUGH FAXED TRANSMITTAL. I AUTHORIZE THE PHYSICIANS OF SADDLEBACK PULMONARY ASSOCIATES AND COAST MEDICAL GROUP TO RELEASE INFORMATION TO MY INSURANCE COMPANY OR WORKER'S COMPENSATION CARRIER ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I AUTHORIZE MEDICARE TO FURNISH TO THE PHYSICIANS OF SADDLEBACK PULMONARY ASSOCIATES AND/OR COAST MEDICAL GROUP ANY INFORMATION REGARDING MY MEDICAL CLAIMS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.

Signature _________________________________________ Date_______________ __Relationship to Patient__________________________

# Saddleback Pulmonary Associates and Coast Medical Group

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Patient name (Please print) ___________________________________

## Past Medical History:

| | | | |
|---|---|---|---|
| __ High blood pressure | __ Irregular Heart beat | __ Heart murmur | __ Pacemaker |
| __ Heart failure | __ Heart attack | __ Stent | __ Anemia |
| __ Diabetes | __ Angina/Chest pain | __ Bypass surgery | __ Stroke (CVA) |
| __ Valve problems | __ Gout | __ Elevated cholesterol | __ Lung disease |
| __ Enlarged heart | __ Ulcer disease | __ Thyroid disease | __Kidney disease |
| __ Tumors | __ Sleep apnea | __ COPD | __ Cancer |

## Surgical History:

Date or age:

1. __________________________________________________ __________________________________________________
2. __________________________________________________ __________________________________________________
3. __________________________________________________ __________________________________________________
4. __________________________________________________ __________________________________________________

## Family History:

Present age or Age at death — Medical Problems/Cause of death

Mother ________ _______ __________________________________________________

Father ________ _______ __________________________________________________

Any other blood relatives with diabetes, high blood pressure, or heart disease?

______________________________________________________________________________________________

## Allergies to Medications:

1. ___________________________________ 2. ___________________________________ 3. ___________________________________

## Current Medications:

1. _________________________________Dose ______________Directions___________________________________________
2. _________________________________Dose ______________Directions___________________________________________
3. _________________________________Dose ______________Directions___________________________________________
4. _________________________________Dose ______________Directions___________________________________________
5. _________________________________Dose ______________Directions___________________________________________
6. _________________________________Dose ______________Directions ___________________________________________

Pharmacy: ____________________________________________ City: ___________________________________________________

## Social History:

Do you or did you smoke? NO YES If yes, packs per day ____ How many years? _______ Quit date?______

Alcohol consumption per day: ___________________________ Caffeine consumption per day: ________________________________

Occupation (or retired?): _________________________________________________________________________________

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# IMPORTANT INFORMATION REGARDING YOUR HEALTH INSURANCE

Please be aware that most insurance plans now require prior authorization for services such as CAT SCANS, PET SCANS, MRI's ect. Prior to having any radiology services please contact your insurance company to see if authorization is required. If you require authorization, please contact our office and allow 5 business days for authorization to be obtained before you have ordered services. Office is unable to obtain retro-authorization after services have been rendered. Failure to obtain necessary authorization may result in higher out of pocket expenses to you, the patient.

______________________

PATIENT SIGNATURE

______________________

DATE

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## Patient Record of Disclosure

Health Insurance Portability and Accountability Act (HIPAA) is a regulation passed by the Federal Government to give individuals the right to request a restriction on uses and disclosures of their protected health information. HIPAA also allows individuals the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of home or by restricting information to a select group of people.

**For more information on HIPAA visit: http://www.cms.hhs.gov/hipaa/hipaa2/defalt.asp**

☐ I wish to allow all necessary disclosures by **SPA and/or Coast Medical Group**, including but not limited to treatment records, payment information, and health care operations. I may be contacted by phone at home or at work. It is okay to leave a detailed message as necessary if I can not be reached. I will allow mail to be sent to my home, work, or office in an attempt to contact me at the numbers/addresses I provided on the Patient Information Questionaire.
SIGNATURE______________________________________________PRINT_______________________________________________

OR

☐ I wish to allow all necessary disclosures by **SPA and/or Coast Medical Group**, including but not limited to treatment records, payment information, and health care operations. I may be contacted by phone at home or at work. It is okay to leave a detailed message as necessary if I can not be reached. I will allow mail to be sent to my home, work, or office in an attempt to contact me at the numbers/addresses I provided on the Patient Information Questionaire.

**EXCEPT as I have outlined here**:

______________________________________________________________________________________________

______________________________________________________________________________________________

___________(use reverse for more space)

SIGNATURE______________________________________________PRINT_______________________________________________

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Patient Name:____________________________DOB ___/___/____ SS: ____________________________

Please list ALL your Physicians you see & the condition they are treating

| PHYSICIAN NAME | CONDITION BEING TREATED |
|---|---|
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# EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would ***never*** doze or sleep.
1 = ***slight*** chance of dozing or sleeping
2 = ***moderate*** chance of dozing or sleeping
3 = ***high*** chance of dozing or sleeping

| *Situation* | *Chance of Dozing* |
|---|---|
| Sitting and reading | ___ |
| Watching TV | ___ |
| Sitting inactive in a public place | ___ |
| Being a passenger in a motor vehicle for an hour or more | ___ |
| Lying down in the afternoon | ___ |
| Sitting and talking to someone | ___ |
| Sitting quietly after lunch (no alcohol) | ___ |
| Stopped for a few minutes in traffic while driving | ___ |
| **Total score: (add the scores up)** (This is your Epworth score) | ___ |

Patient name:____________________________Date:________________