Patient Personal Information

Patient Name: ____

Address: ____

City/State: ____ Zip Code: __________________

Home Phone: _______________________ Work Phone: _______________________ Cell: _________________________

Birth date: __________________ Sex: ☐ **M** ☐ **F** Marital Status: ___________ Fax#: ________________________

Email: ____ Soc.Sec. #: ___________________ Driver Lic #: ____________

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian ☐Hispanic ☐Black/African American
☐White ☐Other ☐Other Pacific Islander

Language: ☐English ☐Indian ☐Russian ☐Spanish ☐Other

Pharmacy/Name/City: ________________________________ Pharmacy Phone: ______________________

Pharmacy Fax: ____ Height: _______ Weight: _______

Employment: ☐ Retired ☐ Full Time ☐ Part-time ☐ Self Employed

Company Name: _____________________________________Position:_________________________

Address: _________________________________City/State: _______________________ Zip: __________

Work Phone: ___________________ Ext:____/ Other: __________________ Fax# _____________________

Best Phone# to contact you directly: ____
(To confirm your appointments)

Spouse/Guardian Information

Name: ____ SS#_________________________

Birth date: ________________ Employer Name: ____

Work Phone____________________ Ext: _________ Cell# __________________Other:_______________

Payment Information: ☐ Insurance #1 ☐ Insurance#2 ☐Cash

Primary Ins: __________________ **Secondary Ins** ____________________

Policy Holder: ___________________ Policy Holder: _____________________

Referred By: ____

Emergency Contact

Name of Contact: ____Relationship:_____________________

Street/City/State/Zip: ____ Phone: ________________________

I hereby give authorization that payment of insurance benefits be made directly to **Newport Coast Cardiology** for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I agree to pay all the cost of collection and reasonable attorney fees. I hearby authorize for the release of all information necessary to secure the payment of benefits.
I hereby give authorization for the practice to access my Rx external history.

Signature: ____ **Date:** __________

Name:______________________________ Age: _________ Date: ___________

Please List All Medications You Are Taking **Please List All Drug Allergies**

Please List All Medications You Are Taking	Please List All Drug Allergies

HEALTH QUESTIONAIRE

Patient Name: ____ Age: _______ Date: _________

HISTORY OF PAST ILLNESS

	DATE	TYPE	HOSPITAL
Serious Illnesses	________	______________________	____________________
	________	______________________	____________________
	________	______________________	____________________
Operations	________	______________________	____________________
	________	______________________	____________________
	________	______________________	____________________
Injuries	________	______________________	____________________
	________	______________________	____________________
	________	______________________	____________________

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE (at death)	CAUSE
Father	______	______________	______	______________
Mother	______	______________	______	______________
Siblings	_____ B / S	______________	_____ B / S	______________
Brother (B)	_____ B / S	______________	_____ B / S	______________
Sister (S)	_____ B / S	______________	_____ B / S	______________
	_____ B / S	______________	_____ B / S	______________
Husband/Wife	______	______________	______	______________
Children	_____ S / D	______________	_____ S / D	______________
Son (S)	_____ S / D	______________	_____ S / D	______________
Daughter (D)	_____ S / D	______________	_____ S / D	______________

SOCIAL HISTORY

Birthplace ____

Circle one: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Do you have dependents at home? ☐Yes ☐No If yes, how many? ____________

Alcoholic beverages: ☐Never ☐Rarely ☐Moderately ☐Daily

Tobacco: ☐Never smoked ☐Quit – when? _______ ☐Packs/Day ____________

Drugs (illicit): ☐None ☐In Past ☐Rarely ☐Frequently

Exercise: Type ____________________________________ Frequency ____________

Are you currently dieting? ☐Yes ☐No If so, what type of diet? ________________

Occupation: ____

Any known allergies? ____

Patient Name: ______________________________ Age: __________ Date: ________________

REVIEW OF SYSTEMS

Do you have any of the following?

GENERAL:

- Have been in good health most of your life?.................... YES NO
- Any recent weight change?…………………………………… YES NO

SKIN:

- Skin disease…………………………………………….…. YES NO
- Jaundice…………………………………………………… YES NO
- Hive, edema, rash, or itching…………………………… YES NO
- Frequent skin infection or boils………………………… YES NO
- Abnormal pigmentation or color……………………….. YES NO

HEAD-EYE-EARS-NOSE-THROAT:

- Headaches or migraines……………………………….... YES NO
- Eye disease or injury…………………………………… YES NO
- Do you wear eye glasses or contacts…………………… YES NO
- Double vision or vision loss……………………………. YES NO
- Glaucoma………………………………………………… YES NO
- Cataracts………………………………………………... YES NO
- Itchy, sneezy, or runny nose……………………………. YES NO
- Nosebleeds……………………………………………... YES NO
- Chronic sinus trouble………………………………….... YES NO
- Trouble with smell or taste…………………………….. YES NO
- Ear disease………………………………………………. YES NO
- Trouble hearing…………………………………………. YES NO
- Dentures/Partials……………………………………….. YES NO
- Sore mouth or tongue…………………………………… YES NO
- Sore throat or recent tonsillitis…………………………. YES NO

NECK:

- Stiffness…………………………………………………. YES NO
- Enlarged glands…………………………………………. YES NO

BREAST (FEMALES):

- Lumps…………………………………………………….. YES NO
- Pain or discharge……………………………………….. YES NO
- Mammogram…………………………………………….. YES NO
- Date of last mammogram……………………………… ________________

RESPIRATORY:

- Cold symptoms now…………………………………….. YES NO
- Coughing up blood……………………………………… YES NO
- Asthma or wheezing…………………………………….. YES NO
- Difficulty breathing………………………………………YES NO
- Pleurisy or pneumonia………………………………….... YES NO
- Tuberculosis…………………………………………….. YES NO
- Any trouble with lungs………………………………….. YES NO

CARDIOVASCULAR:

- Chest pain or angina…………………………………….. YES NO
- Shortness of breath at night………………………………YES NO
- Heart attacks or heart trouble…………………………….YES NO
- Heart murmur…………………………………………….YES NO
- Palpitations……………………………………………… YES NO
- Swelling of the feet or ankles……………………………YES NO
- Rhumatic fever……………………………………………YES NO
- Pain in legs or buttocks when walking………………….. YES NO

GASTOINTESTINAL:

- Does food stick in throat?.. YES NO
- Peptic ulcer (stomach or duodenal)…………………….. YES NO
- Vomiting blood or food…………………………………. YES NO
- Gallbladder problems…………………………………… YES NO
- Liver disease or hepatitis……………………………….. YES NO
- Cramping or pain in the abdomen………………………. YES NO
- Bleeding or pain with bowel movements………………. YES NO
- Black stool……………………………………………… YES NO
- Hemorrhoids…………………………………………….. YES NO
- Recent change in bowel habits…………………………. YES NO
- Frequent diarrhea……………………………………….. YES NO
- Constipation…………………………………………….. YES NO
- Hernia or hernia surgery………………………………… YES NO

GENITOURINARY:

- Kidney disease or failure……………………………….. YES NO
- Kidney stones…………………………………………… YES NO
- Burning or painful urination……………………………. YES NO
- Blood in urine…………………………………………… YES NO
- Protein in the urine……………………………………… YES NO
- Bladder kidney infections………………………………. YES NO
- Frequent urination………………………………………. YES NO
- Recent change in night time urination…………………... YES NO
- Venereal disease………………………………………… YES NO
- Prostate problems (males)………………………………. YES NO

GYNECOLOGICAL (FEMALES):

- Number of pregnancies…………………………………. ________________
- Number of miscarriages………………………………… ________________
- Last menstrual period…………………………………… ________________
- Date of last pap smear………………………………….. ________________
- Vaginal discharge……………………………………….. YES NO

MUSKULOSKELETAL:

- Arthritis…………………………………………………. YES NO
- Gout……………………………………………………... YES NO
- Varicose veins……………………………………………YES NO
- Chronic back pain……………………………………….. YES NO

HEMATOLOGIC:

- Blood disease…………………………………………….YES NO
- Phlebitis…………………………………………………. YES NO
- Abnormal bruising or bleeding………………………….. YES NO
- Anemia…………………………………………………... YES NO

ENDOCRINE:

- Diabetes…………………………………………………. YES NO
- Thyroid disease………………………………………….. YES NO
- Abnormal hair growth or loss…………………………… YES NO
- Hormone therapy………………………………………... YES NO

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NEWPORT COAST CARDIOLOGY, INC

In order to better serve your medical care, this office will now implement the following policies:

APPOINTMENTS

- Failure to keep or cancel your scheduled appointment within 24 hours time will necessitate a cancellation fee of $25.00.
- A return visit following any procedures, radiology testing, or laboratory analysis are usually needed. If a doctor requests that you schedule a follow-up, please make a follow-up appointment. Telephone consultations cannot be made in lieu of a follow-up appointment.

CO-PAYMENTS/DEDUCTIBLES

- Co-payments are due at the time services are rendered. Payment of cash or check only; no credit cards. A $10.00 billing fee will be charged every time a statement is sent to collect a co-payment.
- If you present for your appointment without your co-pay, your appointment will be rescheduled.
- Unmet deductibles will be collected at the time of an office visit and prior to any tests, procedures.

PAYMENTS

- There will be a $25.00 fee charged for all returned checks.
- If delinquent payments have not been made within 3 months, a 100% billing fee will be added to your account before it is sent to the collection agency.

PRESCRIPTIONS

- Written prescriptions will be given at the time of an office visit. Please be aware of your medication needs at every office visit. Your physician will give you enough refills of all your routine medications to last until they want to see you again. If you need a refill prior to an office visit, please contact your pharmacy and have them fax a request to our office. This office cannot guarantee that your request for a refill can be completed the same day as the request (please be aware of your medication needs before you completely run out of those medications).

I UNDERSTAND AND ACKNOWLEDGE THE ABOVE OFFICE POLICIES.

____

Patient/Responsible Party Signature　　　　　　　　　　Date

____

Print Name　　　　　　　　　　　　　　　　　　　　Date of Birth

Acknowledgement of Receipt of Notice of Privacy Practices

NEWPORT COAST CARDIOLOGY, INC

DIPTI ITCHHAPORIA, M.D., F.A.C.C.

TEL: (949) 548-6634 FAX: (949) 548-1431

I hereby acknowledge that I received a copy of Newport Coast Cardiology's Notice of Privacy Practices. This notice describes how Newport Coast Cardiology may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law, that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.

If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), we will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to other through he HIE.

To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722.

Print Patient Name: ____

Signature: ____ Date: _________________

If not signed by the patient, please indicate relationship:

☐ Parent or Guardian ☐ Other: ________________

In general, the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone: _____________________

- ☐ OK to leave message with detailed information
- ☐ Leave messages with call-back number only

☐ Work Telephone: _____________________

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number: ______________

☐ Other: ____

____

NEWPORT COAST CARDIOLOGY, INC

Dipti Itchhaporia, M.D., F.A.C.C.

Patient Financial Agreement

Dear Patient or Guardian:

Our goal is to provide you with the best medical care available. A clear understanding of our financial arrangement is essential for a successful doctor/patient relationship.

Our office will call your insurance company to verify eligibility and benefits. We cannot be held responsible for information received when verifying insurance benefits since it is not a guarantee of payment or eligibility. It is **your responsibility** to be aware of any limitations such as pre-existing clauses, second opinion requirements, etc written in your policy. It is recommended that you also contact your insurance company regarding your benefits and coverage. For those patients using the **POS** option of your plan; you must contact your insurance carrier prior to performing any procedures to alert them that you are going out of your plan to use the PPO option.

Charges for your treatment will be billed to your insurance company. However, if your insurance company has not paid their portion of the charges within 60 days, the account will revert to **your responsibility**. Regarding insurance payments, the phrases “more than the allowable charge” or “exceeds usual and customary amount” may be used by your insurance company to states that fees may exceed their allowance. If there is a major discrepancy between our fees and your insurance carrier’s allowance, our office will assist you in providing your insurance company with additional information as needed for your claim.

My signature below indicates that I have read and understand the above statements. I have receive a copy of this agreement for my records.

Signed: ____ Date: ______________

Witness: ____ Date: ______________