Patient Registration Form

Patient Name:________________ **Age:**______ **Date of Birth:**______________

Race:______________ **Ethnicity:**______________ **Preferred Language:**______________

Address:________________________ **City:**__________ **State:**______ **ZIP:**________

Home Phone:______________ **Cell Phone:**______________ **Work Phone:**______________

Email:________________________________ **SSN:**______________

Marital Status(Check One): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Birth Gender (Check One): ☐ Male ☐ Female ☐ Other ☐ Decline To Answer

Current Gender(Check One): ☐ Male ☐ Female ☐ Non-Binary ☐ Other ☐ Decline to Answer
☐ Transgender Male (FTM) ☐ Transgender Female (MTF)

Gender Identity(Check One): ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other ☐ Decline to Answer

Primary Physician (PCP):______________ **Referring Physician:**______________

Employer:________________________ **Occupation:**______________

Drug/Food Allergies: ______________ **Diabetic:** ☐ Yes ☐ No **Dialysis Days:** ☐ M/W/F ☐ T/Th

Emergency Contact Information

Name:________________________ **Relationship:**______________

Address:________________________ **City:**__________ **State:**______ **ZIP:**________

Home Phone:______________ **Cell Phone:**______________ **Work Phone:**______________

Name:________________________ **Relationship:**______________

Address:________________________ **City:**__________ **State:**______ **ZIP:**________

Home Phone:______________ **Cell Phone:**______________ **Work Phone:**______________

Employer Name:________________________ **Employer #:**______________

Insurance Information

Primary Insurance: ____________________

Name of Insured: ____________________ **Date of Birth:** ____________________

Insurance ID# : ____________________ **Group #:** ____________________

Secondary Insurance: ____________________

Name of Insured: ____________________ **Date of Birth:** ____________________

Insurance ID# : ____________________ **Group #:** ____________________

CSMG Financial Policy

(Please read and sign below)

ALL CO-PAYS ARE DUE AT TIME OF SERVICE

As a courtesy to our patients, we will bill your insurance company for hospital and surgical fees provided you have presented us with all necessary billing information. It is the sole responsibility of the patient to ascertain their benefit information with the insurance company. After we receive the payment from your insurance company, we will then send you a statement of any remaining balance left on your account which is due within 30 days. We will be happy to discuss any fees or financial issues with you.

MEDICARE PATIENTS: I request payment of authorized Medicare benefits be made either to me or on my behalf to the provider indicated to the claim. I authorized any holder of medical information about me to be released to the Healthcare Financing Administration and its agents to determine these benefits, or the benefits payable for the related services.

I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize the release of any medical information necessary to process this insurance claim. A copy of this signature is as valid as the original.

I have read and fully understand the abovementioned CSMG Financial Policy.

Signature: ____________________

Date: ____________________

Patient Financial Agreement Form

Date: ________________

Physician: ____________

Patient Name:____ **Date of Birth:**________________________

The Physicians of Coastal Surgeons require this form to be signed by our Patients. We appreciate your cooperation. If you have any questions, please speak to our Billing Department. We are pleased to assist with your insurance.

FINANCIAL RESPONSIBILITY: I understand that I will be responsible for any charge incurred by **not providing the most current, and accurate insurance information** to Coastal Surgeons. Exceptions to this policy: those patients with current authorization with HMO, a state federally funded program, or a PPO in which Coastal Surgeons is currently contracted with.

I understand that with the exemptions explained above, I am personally responsible for any medical fees I will incur with Coastal Surgeons.

Print Name:________________________ **Signature:**____________________ **Today's Date:**____________________

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: *I hereby authorize payment for medical services provided directly to Coastal Surgeons Physicians*.

Print Name:________________________ **Signature:**____________________ **Today's Date:**____________________

Coastal Surgeons will be responsible for billing and collection on Professional charges. Coastal Surgeons is not responsible for any bills you may receive from the hospital, including Anesthesia, Pathology, or Laboratory services when surgery is performed. Please be aware that most surgery cases performed require an assistant to be present, not all assistants maybe contracted with your insurance policy. We will do our best to acquire a contacted assistant, but this is solely based on availability of the assistant.

I understand and agree with the terms and conditions listed above.

Print Name:________________________ **Signature:**____________________ **Today's Date:**____________________

Notice of Privacy Practices

This notice describes how health information about our patients may be used and disclosed, and how you can get access to your health information. This, required by the Privacy Regulations, is created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy

Our Practice is dedicated to maintaining the privacy of your health information. We are required by the law to maintain the confidentiality of your health information.

Use and Disclosure of Your Health Information in Certain Special Circumstance

The following circumstances may require us to use or disclose your health information:

1) To Public Health authorities/Health oversight agencies that are authorized by law to collect information.
2) Lawsuits and similar proceedings in response to a court or administrative order.
3) If required by Law Enforcement Official(s).
4) When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5) If you are a member of U.S. Armed Forces or Foreign military (including veterans) and if required by the appropriate authorities.
6) To federal official(s) for intelligence and national security activities authorized by law.
7) To correctional institutions or law enforcement official(s) if you are an inmate, or under custody of a law enforcement official.
8) For Workers' Compensation and similar programs.
9) Data that is collected by Coastal Surgeons, which does not include the identity of the patient may be utilized for research purposes.

Your Rights regarding your Health Information:

1) You can request that out practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2) You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care: such as family members, or friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when required by law, in emergencies or when the information is necessary to treat you.
3) You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical and billing records, but not including psychotherapy notes. You must submit your request in writing to Coastal Surgeons who will have up to 30 days to comply.
4) You may ask us to amend health information if you believe it is incorrect or incomplete, if the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Coastal Surgeons who will have 60 days to respond. You must provide us with a legitimate reason that supports you request for amendment.
5) You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy of this notice by contacting our front desk receptionist.
6) If you believe that your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of Use, Department of Health and Human Services. To file a complaint, contact Coastal Surgeons at (760)724-5352. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7) Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice, or our health information privacy policies, please contact your physician.

General Authorization to Release Health Information

I hereby authorize the release of my personal health information to any healthcare provider approved by my treating physician. I understand that I may cancel this authorization at anytime by notifying my treating physician in writing.

Print Name:________________________ **Signature:**____________________ **Today's Date:**____________________

Coastal Surgeons Notice of Privacy Practices

I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Print Name:________________________ **Signature:**____________________ **Today's Date:**____________________

Appointment No-Show / Surgery Cancellation Agreement

Same Day Cancellations or No-Show for Office Visits

$50.00 Fee

(Please contact our office 24 hours prior to avoid fees)

Surgery Cancellations less than 48 Hours

$250.00 Fee

(If surgery is cancelled 48 hours prior to scheduled surgery date, NO FEE will be charged)

I acknowledge that I have read and understand the above information.

Patient Name: ______________________________

Signature: ______________________________

Date: ______________________________

Medication List

Date of Visit:________________ **Date of Birth:**__________________

Patient Name:____

Please write in current **PRECRIBED** or **OVER-THE-COUNTER** medications.

☐ No medication(s) being taken

Name of Medication	Dosage	Directions	Prescribed By

Do you take any of the following?

Aspirin ☐ No ☐ Yes *If **YES**, how much?* ____________

Coumadin ☐ No ☐ Yes *If **YES**, how much?* ____________

Drug Allergies:____

____ ☐ No Drug Allergies

Pharmacy Name:________________________________ **Pharmacy Phone #:**__________________________

Pharmacy Address:________________________________ **City:**___________**State:**______ **ZIP:**__________

Health History Questionnaire

Date of Visit:__________________ **Referring Physician:**____

Patient Name:____

Date of Birth:___________________ **Age:**_________ **Birthplace:**______________________________

Reason(s) for Visit:____

____

Allergies: ☐ No Drug Allergies ☐ Yes *If **YES**, please list below)*

____

____

Other Allergies: Iodine: ☐ Yes ☐ No Novocaine: ☐ Yes ☐ No Latex: ☐ Yes ☐ No

Review of Systems (ROS): *Place **Checkmark** in the proper columns.*

Constitution

Chills	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Weight gain over the past 6 months? How much? ______	☐ Yes	☐ No
Weight loss over the past 6 months? How much? ______	☐ Yes	☐ No

Head / Eyes / Ears / Nose / Throat:

Ear Pain	☐ Yes	☐ No
Eye Pain	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
Nasal Drainage	☐ Yes	☐ No
Sinus Pressure	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No
Visual Changes	☐ Yes	☐ No

Respiratory:

Chronic Cough	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Known TB Exposure	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

COASTAL SURGEONS

Health History Questionnaire

Cardiovascular:

Chest Pain	☐ Yes	☐ No
Edema	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No

Gastrointestinal:

Abdominal Pain	☐ Yes	☐ No
Blood in Stool	☐ Yes	☐ No
Change in Stool	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Loss of Appetite	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No

Genitourinary:

Urinary Frequency	☐ Yes	☐ No
Urinary Incontinence	☐ Yes	☐ No
Urinary Retention	☐ Yes	☐ No

Metabolic/Endocrine:

Cold Intolerance	☐ Yes	☐ No
Heat Intolerance	☐ Yes	☐ No

Neurological:

Dizziness	☐ Yes	☐ No
Extremity Numbness	☐ Yes	☐ No
Extremity Weakness	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Memory Loss	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

Psychiatric:

Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No

COASTAL SURGEONS

Health History Questionnaire

Integumentary:

Brittle Hair	☐ Yes	☐ No
Brittle Nails	☐ Yes	☐ No
Hair Loss	☐ Yes	☐ No
Hives	☐ Yes	☐ No
Mole Changes	☐ Yes	☐ No
Rash	☐ Yes	☐ No
Skin Lesions	☐ Yes	☐ No

Musculoskeletal:

Back Pain	☐ Yes	☐ No
Joint Pains	☐ Yes	☐ No
Joint Swelling	☐ Yes	☐ No
Muscle Weakness	☐ Yes	☐ No
Neck Pain	☐ Yes	☐ No

Hematological/Lymphatic:

Bleeds Easily	☐ Yes	☐ No
Bruises Easily	☐ Yes	☐ No

Immunological:

Contact Allergy	☐ Yes	☐ No
Environmental Allergy	☐ Yes	☐ No
Food Allergies	☐ Yes	☐ No
Seasonal Allergies	☐ Yes	☐ No

Operations / Surgeries / Procedures: ☐ No Operations/Surgeries/Procedures

Year	Surgical / Procedure Name:

Health History Questionnaire

Hospitalization(s): ☐ No Hospitalization(s)/Admission(s)

Year	List reasons of Hospitalization(s) / Admission(s)

Major Medical Illness: ____________________

____

Tobacco Use: ☐ Curren ☐ Former ☐ Never

If **current** or **former smoker,** what type of tobacco product? *Check all that apply.* ☐

☐ Cigarettes or Cigars ☐ Pipe ☐ Chewing ☐ Smokeless ☐ E-Cigs/Vape

Alcohol Use: ☐ Yes *If YES, what type?* ☐ *How Many?* ☐ ☐ No ☐ Former

Caffeine Use: ☐ Yes *If YES, what type?* ☐ *How Many?* ☐ ☐ No ☐ Former

Drug Use: ☐ Yes *f YES, what type?* ☐ *How Many?* ☐ ☐ No ☐ Former

Marital Status(Check One): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Occupation: ____________________ ☐ Retired

Family Medical History: Please write down any medical history that runs in the family such as cancer, major illnesses, or history of colon polyps and/or colon cancer. If deceased, please fill in age and cause of death. Please use the space below for additional information.

Family Member	Age	Medical History/Illness	Cause of Death
Mother			
Father			
Brother			
Brother			
Sister			
Sister			