SOUTH ORANGE COUNTY CARDIOLOGY GROUP

Patient Registration

MRN_____

Patient Information

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check your Primary phone	☐ Home Phone	☐ Work Phone	☐ Cell Phone

Other Name(s) Used	E-mail Address

Gender ☐M ☐F ☐Nonbinary	SSN	Preferred Language	Driver's License

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Life Partner

Preferred Contact
- ☐ Mail
- ☐ Home Phone
- ☐ Day Phone
- ☐ Cell Phone
- ☐ Patient Portal

Ethnicity
- ☐ Cambodian
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Non-Hispanic

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as patient

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary Phone	☐ Home Phone	☐ Work Phone	☐ Cell Phone

SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary Phone	☐ Home Phone	☐ Work Phone	☐ Cell Phone

How did you hear about us?

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the South Orange County Cardiology Group to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize South Orange County Cardiology Group to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until canceled by me in writing.

_____ _____

Signature of Patient/Responsible Party | Date

_____ _____

Name of Patient/Responsible Party (Please Print) | Relationship to Patient

SOUTH ORANGE COUNTY CARDIOLOGY GROUP

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
City & Cross Streets	City & Cross Streets
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Size (mg)	Frequency/Directions

Allergies and Type of Reaction: (Medication, Food, Bees, etc.)

☐ No Known Allergies

Medical History – Check if you have ever experienced the following conditions, and year of onset

Condition	Year	Condition	Year
☐ None		☐ GERD (Reflux)	
☐ Allergies		☐ Heart Attack	
☐ Anemia		☐ Heart Failure	
☐ Angina		☐ Hepatitis C	
☐ Anxiety/Depression		☐ Hyperlipidemia (Chol/TG)	
☐ Arthritis		☐ Hypertension	
☐ Arrhythmia (heart irregularity)		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Peptic Ulcer Disease	
☐ Blood Clots		☐ Pericarditis	
☐ Cancer – Type		☐ Renal Disease	
☐ Coronary Artery Disease		☐ Seizure Disorder	
☐ COPD (Emphysema)		☐ Stroke/TIA	
☐ Crohn's/Ulc Colitis		☐ Thyroid Disease	
☐ Diabetes		☐ Other	
☐ Gallbladder Disease			

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Surgical History – Check if you have received the following procedures, and year performed			
Surgical Procedures	Year	Surgical Procedures	Year
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/Stent		☐ TURP (Trans-Urethral Resection of Prostate)	
☐ Appendectomy		☐ Prostatectomy	
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery			
☐ CABG (heart bypass)		Female Only	
☐ Carpal Tunnel Release		☐ Augmentation Mammoplasty	
☐ Cataract Extraction		☐ Bilateral Tubal Ligation	
☐ Cholecystectomy		☐ Breast Biopsy	
☐ Colectomy		☐ Cesarean Section	
☐ Colostomy		☐ D and C	
☐ Gastric Bypass		☐ Hysterectomy	
☐ Heart Valve Surgery		☐ Mastectomy	
☐ Hernia Repair		☐ Myomectomy	
☐ Hip Replacement		☐ Reduction Mammoplasty	
☐ Knee Replacement			
☐ Liver Biopsy		Other	
☐ Pacemaker/Defib		☐	
☐ Small Bowel Resection		☐	
☐ Thyroidectomy		☐	
☐ Tonsillectomy		☐	

Health Maintenance – Check if you have received the following, and date of most recent exam			
Exam	Date	Exam	Date
☐ Bone Density Scan		☐ Lipid Panel	
☐ Cardiac Stress Test		☐ Pneumococcal Vaccine	
☐ Colonoscopy		☐ Pneumonia Vaccination	
☐ Echocardiogram		☐ Pulmonary Function Test	
☐ EKG		☐ Shingles Vaccination	
☐ Flu Shot		☐ Tetanus Vaccine	

More Information			
Occupation		Employer	
Do you have children? ☐ Yes ☐ No How many?		Female(s)	Male(s)
Tobacco Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit: Year Started:	☐ Chewing ☐ Pipe Brand: ☐ Cigar ☐ Cigarette ☐ Smokeless	
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit: Year Started:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:	
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week:	Sleep Pattern: ☐ Changes ☐ No Changes	
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit: Year Started:	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other:	

SOUTH ORANGE COUNTY CARDIOLOGY GROUP

Family History – Check if any family member(s) has had any of the following conditions

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Birth Year							
Age at Death							
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐	☐	☐
CAD (Heart Attack)	☐	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Disease	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
PVD	☐	☐	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

Family History (continued) - Please provide further information regarding family history

e.g. Paternal grandfather had a heart attack at 51 years old.

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Insurance Eligibility & Benefits

Primary Insurance Plan		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date	Part B Effective Date

Other Insurance Coverage for Patient		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

☐ I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to South County Orange Cardiology Group for any medical or surgical services rendered by its affiliated medical groups to me or a member of my family. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

☐ I understand that I am eligible for benefits through my HMO policy. I understand that my assigned IPA/Medical Group chosen for my benefits is listed above. I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me), will pay in full all such charges.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

SOUTH ORANGE COUNTY CARDIOLOGY GROUP
OCHeart.com

MRN: _____

Communicating with You

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine's/voice mail.

Please check all boxes that give us permission to use for your communications:

☐ You may contact me by telephone	Phone Number: _____
☐ You may leave a message/voicemail	Phone Number: _____
☐ You may contact me by mail	
☐ You may contact me through email	

Please list any persons you would like to have access to your billing, appointment or health information, such as your spouse, caretaker or other family member. We will ask for additional consent prior to releasing information related to psychiatric services and/or HIV test results.

Name/Phone Number	Relationship	Options
1.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
2.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
3.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
4.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Print) Relationship to Patient

SOUTH ORANGE COUNTY CARDIOLOGY GROUP

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient