Comprehensive Pulmonary and Primary Care
Physicians of Orange County

Patient Registration

Patient Information			
First Name:	Last Name:	MI:	Date of Birth:
Other Name(s) Used:	E-Mail Address:		
Home Phone:	Work Phone:	Cell Phone:	
Address:	City:	State:	Zip:
Gender: ☐ Male ☐ Female	SSN:	Preferred Language:	Driver's License:
Emergency Contact Name:	Emergency Contact Phone:	Relationship to patient:	
Occupation:			

Additional Information:			
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	Preferred Contact: ☐ Mail ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Patient Portal (Follow MyHealth)	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Cambodian ☐ Filipino	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other
Preferred Pharmacy Name and Location:			
Primary Care Provider:	Who were you referred by?		

Responsible Party			
First Name:	Last Name:	MI:	Date of Birth:
Address (if different):	Preferred Phone Number:		
SNN:	Driver's License:	Relationship to Patient:	

Primary Medical Insurance	Secondary medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder SSN:	Policy Holder SSN:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I do hereby consent to and authorize the performance of all treatments, procedures and medical services deemed advisable by the physicians and medical staff of Comprehensive Pulmonary and Primary Care of Orange County, Inc. (CPPC) 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 hereby authorize my CPPC provider to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

Signature of Patient/Responsible Party _____ Date _____

Printed Name of Patient/Responsible Party _____

COMPREHENSIVE PULMONARY AND PRIMARY CARE OF ORANGE COUNTY, INC.

Patient Name: _____ DOB: _____

Medical History (note year diagnosed with details)

- ☐ Allergies _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Atrial Fibrillation _____
- ☐ Bladder/Kidney disorders _____
- ☐ Blood Disorders _____
- ☐ Breast/GYN disorders _____
- ☐ Cancer (Type) _____
- ☐ Chronic eye/ear/nose disorders _____
- ☐ Colitis/Crohn's Disease _____
- ☐ Concussion _____
- ☐ Depression/Anxiety _____
- ☐ Diabetes _____
- ☐ Gastrointestinal disorders _____
- ☐ Heart disorders _____
- ☐ High blood pressure _____
- ☐ High Cholesterol _____
- ☐ Liver Disease/Hepatitis _____
- ☐ Lung/COPD/Emphysema _____
- ☐ Migraine Headaches _____
- ☐ Neurologic/Stroke/Seizure _____
- ☐ Osteoarthritis _____
- ☐ Osteoporosis _____
- ☐ Prostate problems _____
- ☐ Seizure Disorder _____
- ☐ Skin disorders _____
- ☐ Stroke _____
- ☐ Thyroid disorders _____
- ☐ Tuberculosis _____
- ☐ Ulcer _____
- ☐ Others _____
- ☐ _____
- _____

Medications (please list all medications you take)	Dosage

Surgical History (note year)

- ☐ Abdominal _____
- ☐ Appendix _____
- ☐ Breast _____
- ☐ Gall Bladder _____
- ☐ Heart _____
- ☐ Orthopedic _____
- ☐ Uterus/Ovary _____
- ☐ Vasectomy _____
- ☐ Other _____
- _____
- _____
- _____

Past Tests/Vaccinations (note date)

- ☐ Bone density Scan _____
- ☐ Colonoscopy _____
- ☐ EKG _____
- ☐ Influenza Vaccine _____
- ☐ Mammogram _____
- ☐ Lipid (cholesterol) _____
- ☐ PAP test (female) _____
- ☐ Physical Exam _____
- ☐ Pneumococcal Vaccine _____
- ☐ PSA (prostate) _____
- ☐ Pulmonary Function Test _____
- ☐ Tetanus Vaccine _____
- ☐ Treadmill (heart) _____

Family History (please indicate family members with any of the following conditions)

- ☐ Alcoholism _____
- ☐ Alzheimer's Disease _____
- ☐ Asthma/COPD _____
- ☐ Bleeding Disorders _____
- ☐ Cancer (specific type) _____
- ☐ Heart Disease/Heart Attack _____
- ☐ Diabetes _____
- ☐ High cholesterol _____
- ☐ High blood pressure _____
- ☐ Kidney/Renal Disease _____
- ☐ Mental Health disorders _____
- ☐ Obesity _____
- ☐ Osteroarthritis _____
- ☐ Osteroporosis _____
- ☐ Peripheral Vascual Disease _____
- ☐ Stroke _____
- ☐ Cause of sudden death _____
- ☐ Other _____
- _____
- _____

Social History

Single Married Widowed Divorced Separated

Do you have children? ☐ Yes ☐ No If so, how many? _____

Tobacco Use:

Cigarettes: ☐ Never ☐ Previous ☐ Current: packs/day _____

Other Tobacco: ☐ pipe ☐ cigar ☐ chewing ☐ vape ☐ other _____

Caffeine Use: ☐ Yes ☐ No Cups/day _____

Alcohol Use: ☐ Yes ☐ No Drinks/week _____

Drug Use:

Have you used any recreational Drugs? ☐ Yes ☐ No

Sexual Activity:

Sexually Active: ☐ Yes ☐ No ☐ Not Currently

Current Sexual Partners: ☐ Male ☐ Female

Birth Control Method: _____ ☐ Not needed

Have you ever had a sexually transmitted disease(s)? ☐ Yes ☐ No

Are you interested in being screened for STDs? ☐ Yes ☐ No

Female:

Last menstrual period _____ # of Pregnancies _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

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Agreement of Financial Responsibility

Thank you for choosing **Comprehensive Pulmonary and Primary Care of Orange County, Inc.** 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.

- A photo ID is required for all patient visits. We will ask to make a copy of your ID and insurance card for our records. Proof of insurance is required for all patients that are not paying cash at time of service. 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.
- We require all patients to pay their copay at the time of service. This arrangement is part of your contract with your insurance company. We accept cash, check, and credit cards. If a check is returned for any reason, you will be charged a $25 fee in addition to the amount of the check.
- 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. Please contact your insurance company with any questions about your benefits and coverage.
- 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.
- We participate in most insurance plans. If we have a contract with your insurance company we will bill your insurance company first, and then bill you for any amount determined to be your responsibility, less what was collected at the time of service (copay amount). 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, we will, as a courtesy, file a claim with your insurance carrier. Please understand some insurance coverages have out-of-network benefits that may be subject to deductibles and higher out of pocket responsibility from you. If you receive services that are part of an out-of-network benefit, your portion of financial responsibility may be higher than if you used an in-network provider. Once your insurance processes the claim, we will send you a statement for your balance due. Payment is due upon receipt of the statement.
- Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. We will provide you with an estimate of these costs should the issue present itself. We collect payment based on this estimate at the time of visit.
- Patients with an outstanding balance of 60 days or more overdue must make payment arrangements prior to scheduling future appointments. Chronic nonpayment may result in referral of balance to an outside collection agency and termination of physician services – please help us to avoid this.

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.

_____	_____
Printed Name (Patient/Parent or Legal Guardian)	Date
_____	_____
Signature (Patient/Parent or Legal Guardian)	Relationship to Patient

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to **Comprehensive Pulmonary and Primary Care of Orange County, Inc.** When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

We reserve the right to charge a thirty dollar ($30.00) fee to any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice. Multiple instances of No Shows may result in termination from the practice

The potential fee will be charged to the patient, not the insurance company, and is due at the time of the patient's next office visit. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Front Office Manager.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its

terms.

Printed Name (Patient/Parent or Legal Guardian)	Date
Signature (Patient/Parent or Legal Guardian)	Relationship to Patient

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Physicians of Orange County

Patient Name:_____

Patient DOB:_____

Consent to Email or Text Message Usage

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

____ **(Patient Initials)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

Cell Phone Number (authorized): _____

Email Address (authorized): _____

Patient Signature: _____

Date: _____

Revocation ***(please "X" all that apply)***

☐ I hereby revoke my request to receive any future appointment reminders, feedback, and general health information via **email**.

☐ I hereby revoke my request to receive any future appointment reminders, feedback, and general health information via **text message**.

Patient Signature: _____

Practice Representative Signature: _____ **Date:** _____