Laguna Cardiology

Dawn Atwal MD, Inc
31852 S. Coast Hwy #410
Laguna Beach, CA 92651
P: 949.516.2020 F: 949.516.2008

Patient Information Questionaire

Patient:

Patient Name_____ Birth date _____ Age_____

Patient Address_____

City, State_____ Zip Code_____

Cell Phone_____Home Phone_____ Email _____

Sex_____ __ Marital Status _____ Social Security # _____

*EMERGENCY CONTACT:

Name: _____ (Relation): _____Phone # _____

Primary care physician:_____

Pharmacy: _____ Street: _____City: _____

Responsible Party: (if different) or Spouse Info.

Patient Name_____ Birth date _____ Age_____

Patient Address_____

City, State_____ Zip Code_____

Cell Phone_____Home Phone_____ Email _____

Employer_____Occupation_____

AUTHORIZATION FOR RELEASE OF INFORMATION AND INSURANCE ASSIGNMENT

I hereby authorize assignment and payment directly to Dawn Atwal MD, Inc., 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.

Dawn Atwal MD, Inc., 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 Dawn Atwal MD, Inc.

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 Dawn Atwal MD, Inc TO OBTAIN ANY MEDICAL INFORMATION THEY MAY NEED TO PARTICIPATE IN MY MEDICAL CARE.

I AUTHORIZE THE PHYSICIANS OF Dawn Atwal MD, Inc TO RELEASE INFORMATION, INCLUDING FAXED INFORMATION, TO ANY PERSON PARTICIPATING IN MY MEDICAL CARE. I RELEASE Dawn Atwal MD, Inc 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 Dawn Atwal MD, Inc 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 Dawn Atwal MD, Inc. ANY INFORMATION REGARDING MY MEDICAL CLAIMS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.

Signature_____ Date_____

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Symptoms:

__ Chest pain __ Shortness of breath __ Palpitations __ Dizziness __ Fainting

Past Cardiac History:

__ Hypertension	__ Atrial fibrillation	__ Heart murmur	__ Pacemaker
__ Heart failure	__ Heart attack – date: _____	__ Stent - date: _____	__ Defibrillator/ICD
__ Diabetes – type 1 or 2	__ Bypass surgery (CABG)	__ Stroke (CVA)	__ Anemia
__ Hyperlipidemia	__ Lung disease	__ Sleep apnea	__ COPD

Other Past Medication History:

_____

Surgical History: Date:

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 _____
7. _____ Dose _____Directions _____

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

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 **Dawn Atwal MD, Inc**, 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**_____

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Cancellation Policy

At Laguna Cardiology, our goal is to provide quality cardiology care in a timely manner. We have implemented a no show, reschedule, and cancellation policy which enables us to better utilize available appointments for our patients. The following policy is with regards to patients who fail to keep their scheduled office procedures.

- Patients who fail to show for their scheduled office procedures (echocardiogram/stress echocardiogram) appointments or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No show/Reschedule/Cancellation" fee of $50.

- This fee is not covered by insurance and is therefore the sole responsibility of the patient.

How to Cancel Your Appointment
To cancel or reschedule appointments call our office at 949-516-2020. If you have any problems getting through, you can leave a message with your name, appointment date, and reason for cancellation reason or request for rescheduling.

_____ _____
Patient Signature Date

_____
Patient Printed Name