



CARDIO-PULMONARY ASSOCIATES  
MEDICAL GROUP

*Serving the Monterey Peninsula since 1979*

30 Garden Court • Monterey, CA 93940  
Phone: (831) 646-8570 Fax: (831) 646-5435

Dear Patient,

The Doctors and Staff of Cardio-Pulmonary Associates Medical Group, welcome you as a new patient. Our job is to serve your medical needs in a professional, caring, and timely manner.

We have enclosed new patient information and personal history sheets. **Please complete these documents and bring with you to your appointment.** If you have any questions regarding these forms or your appointment, please call us at (831) 658-2187 (option #1).

If you are transferring to our office from another provider it is your responsibility to make sure that your Doctor's office either sends your records to us before your appointment date or gives them to you to bring to your consultation visit. Any recent diagnostic procedures lab work, etc. is helpful for us to have in your record and helps facilitate your visit with our Physician.

We look forward to seeing you.

**Cardiology:**

- Riaz M. Ahmed, MD, FACC
- Stephen J. Brabeck, MD, FACC
- Nicholas K. Chee, DO, FACC
- Michael T. Galloway, MD, FACC
- Thomas K. Kehl, MD
- M. Kerala Serio, MD, FACC

**Interventional Cardiology:**

- Steve S. Lee, MD, FCCP
- Pir W. Shah, MD, FACC

**Nurse Practitioner:**

- Joni Hoffman, FNP

**Physician's Assistant:**

- Larry Rose, PA



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PATIENT REGISTRATION FORM

Date:

First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male Female Social Security: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ e-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Marital Status** *Check one*  Single  Married  Minor

Person responsible for minor: First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

**In case of an emergency, who would you like us to contact?**

Primary Person of Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Secondary Person of Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Name of local friend or relative (not living at same address): \_\_\_\_\_

Relation: \_\_\_\_\_ Home Phone no.: ( ) \_\_\_\_\_ Work Phone no.: ( ) \_\_\_\_\_

**Who may we thank for referring you to this office?**

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**Who are your Primary Care Physician and General Dentist?**

Primary Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

General Dentist: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

How would you like for Cardio-Pulmonary Associates Medical Group, Inc. to remind you of your future appointments? *Check one* E-mail Telephone Call

**PLEASE COMPLETE ALL SECTIONS**  
*(PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST.)*

**Primary Insurance:** \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_ Plan #: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Co-Pay: \_\_\_\_\_ Insurance Phone no.: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Responsible party employed by: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Business Address: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_ Plan #: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Co-Pay: \_\_\_\_\_ Insurance Phone no.: \_\_\_\_\_

Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Responsible party employed by: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Business Address: \_\_\_\_\_

**Self Pay:**

Identification Card No.: \_\_\_\_\_ Type of identification: \_\_\_\_\_

I hereby authorize CPAMG, Inc. any insurance or other third-party benefits available for health care services provided to me. I understand that CPAMG, Inc. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to CPAMG, Inc., I agree to forward to the practice all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payment to related services.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

OFFICE USE ONLY				
Insurance verified by:	Date:	Deductible:	Co-pay:	Met:



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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a summary of our Financial Policy, which we request you read and sign prior to any treatment.

Cardio-Pulmonary Associates accepts cash, personal checks, VISA, MasterCard, American Express, Discover, and VISA/MC debit check cards. There is a service charge of \$25.00 for returned checks to cover the fee our bank charges us. We realize that people sometimes have financial difficulty and we will work with you. Please call our Billing Office from 8:30 a.m. to 4:30 p.m., Monday through Friday at (831) 646-2173 to discuss payment arrangements.

**Insurance Billing:** If you are not eligible with your insurance at the time of service you are responsible for payment. Once you have supplied us with all your insurance information to include a copy of your insurance card we will submit a claim for services. Secondary insurance is billed as a courtesy, if unpaid after 90 days balance due is patient responsibility.

**PPO:** All co-pays, share of cost, and deductibles are due at time of service. It is your responsibility to know what is covered under your plan.

**HMO or Out of Network Plans:** If you do not have authorization at time of service, you are responsible for unpaid balances. It is your responsibility to know what benefits are available under your plan and what authorization requirements may exist.

**Cash or Private Insurance:** Full payment is due at time of service.

**Minor Patients:** The parents or legal guardian of the minor are responsible for payment.

**Refunds:** Overpayments will be refunded upon written request to the responsible party within 30 days.

**Special Forms:** Completing forms for work, insurance companies, utility companies, and other entities represents a significant cost to the practice. We reserve the right to charge \$20.00 for these forms.

**Collections:** We use a collection agency for unpaid balances. In addition to the amount owed you also will be responsible for the fee charged by the collection agency for the costs of collection.

**Missed Appointments:** We require 24 hour notice for cancellations. We charge \$25.00 for missed appointments.

**I have read and understand the Financial Policy. I agree to this financial policy and assign insurance benefits whenever necessary.**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

Name of patient: \_\_\_\_\_  
Please print

**Treatment of dependents:** The undersigned hereby consents to the care and treatment now and in the future of the patient listed above.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

Relation to patient: \_\_\_\_\_

Verified by: \_\_\_\_\_ Date: \_\_\_\_\_



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AUTHORIZATION TO CHARGE CREDIT CARD

CARDIO-PULMONARY ASSOCIATES MEDICAL GROUP, INC.  
30 Garden Court  
Monterey, CA 93940  
(831) 646-8570

Patient Name: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

I authorize Cardio-Pulmonary Associates Medical Group, Inc. to charge my credit card for the outstanding balance due on my account. I understand that if my credit card company does not accept the charge, I will immediately make payment to the practice for the services rendered.

I understand that I may cancel this authorization at any time, but by doing so I acknowledge that the balance is still my responsibility.

Signature: \_\_\_\_\_

Printed Name of Person Signing: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Credit Card Company: \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Zip Code: \_\_\_\_\_



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I hereby give CPAMG, Inc. (Physicians and/or staff) authorization to speak with the following people regarding my personal health information.

Name	Phone Number	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

I do \_\_\_\_\_ hereby give CPAMG, Inc. (Physicians and/or staff) permission to leave a message with detailed information about my personal health information either on my answering machine or with the person/people noted above.

I do not \_\_\_\_\_ authorize CPAMG, Inc. (Physicians and/or staff) permission to leave a message with detailed information about my personal health information either on my answering machine except with the person/people noted above.

\_\_\_\_\_  
Signature Date: \_\_\_\_\_

NAME:

AGE:

DATE:

### **New Patient Questionnaire**

*The following questionnaire will assist the Cardiologist in thoroughly evaluating your problem. Most of the questions are self-explanatory, requiring a simple circle or short answer. Please ask the receptionist if you have any questions.*

Who referred you to a cardiologist? \_\_\_\_\_

What is the primary problem for which you have been referred? \_\_\_\_\_

### **Cardiovascular History**

• Have you ever been told that you had a heart attack?            Y N

Do you ever have pain, tightness, or discomfort in your chest or arms? Y N

Do you ever have pain or cramping in your legs when walking? Y N

Do you have palpitation or skipped heart beats?    Y N

Have you fainted or passed out in the past year?    Y N

Do you have difficulty breathing?            Y N

Do your ankles swell up? Y N

Do you find physical effort more exhausting now than previously?    Y N

Have you ever been told that you have high blood pressure?            Y N

If yes, in what year was it first detected?

When did you first take medication for high blood pressure?

• Have you ever had rheumatic fever?            Y N

Have you ever been told that you had a heart murmur?    Y N

Have you ever been told that your cholesterol, lipid, or triglyceride level is elevated?

When was your last electrocardiogram (EKG)? \_\_\_\_\_

When was your last chest x-ray? \_\_\_\_\_

## General Medical History

List all medications you are currently taking. If you do not know the name of the medications you have with you, please show them to the receptionist.

(Do not omit birth control pills, diet pills, cold remedies, allergy shots, and laxatives.)

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Are you now allergic to any drugs or other agents?  Y  N

If yes, please list below:

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

If you have ever been hospitalized for any reason, whatsoever, other than childbirth please complete the following:

YEAR	HOSPITAL	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any operations not listed above?  Y  N

If yes, please list below.

YEAR	HOSPITAL	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle any of the illnesses or problems below that you have had in the past and indicate the year when you first had it.

Emphysema, bronchitis, pneumonia, asthma. Year: \_\_\_\_\_

Cough, shortness of breath, blood in sputum: Year: \_\_\_\_\_

Weight loss, poor appetite, severe vomiting, hiatal hernia. Year: \_\_\_\_\_

Heart burn, diarrhea, constipation, indigestion, stomach ulcer Year: \_\_\_\_\_

Hepatitis, jaundice, pancreatitis, diverticulitis. Year: \_\_\_\_\_

Stroke, blindness, paralysis, numbness. Year: \_\_\_\_\_

Thyroid problem, diabetes, high blood sugar. Year: \_\_\_\_\_

Anemia, bleeding, easy bruising. Year: \_\_\_\_\_

Arthritis, joint pain, gout. Year: \_\_\_\_\_

Fractures; Disc, back, or spine disease. Year: \_\_\_\_\_

Cancer, leukemia, tumor growth. Year: \_\_\_\_\_

Kidney stone, bladder infection, blood in urine. Year: \_\_\_\_\_

Have you gained or lost weight in the past 6 months?  Y  N

• If yes, please estimate how much. Gained ( )lbs. Lost ( )lbs.

What would you like to weigh? ( )lbs

Are you on a special diet?  Y  N

• If yes, please describe it. \_\_\_\_\_

### Habits

What form of exercise, if any, do you get? \_\_\_\_\_

Have you ever smoked cigarettes regularly? Y/N

• If yes, how many packs per day at most? \_\_\_\_\_

Have you quit? Y/N

• If no, have you cut down? Y/N

If yes, to how many packs a day? \_\_\_\_\_

Do you drink beer/wine? Y/N

If yes, how many glasses per week? \_\_\_\_\_

Do you drink mixed alcoholic drinks? Y/N

- If yes, how many drinks per week? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Are you disabled? Y/N

### Family History

Has any member of your family had any of the illnesses below?

Diabetes  Y  N Relationship \_\_\_\_\_

High Blood Pressure  Y  N Relationship \_\_\_\_\_

High Cholesterol  Y  N Relationship \_\_\_\_\_

Heart Attacks  Y  N Relationship \_\_\_\_\_

Sudden Death  Y  N Relationship \_\_\_\_\_

Tuberculosis  Y  N Relationship \_\_\_\_\_

Bleeding Disorder  Y  N Relationship \_\_\_\_\_

Is your father living?  Y  N

- If yes, list any serious illnesses: \_\_\_\_\_

- If no, list age and cause of death: \_\_\_\_\_

Is your mother living?  Y  N

- If yes, list any serious illnesses: \_\_\_\_\_

- If no, list age and cause of death: \_\_\_\_\_

Number of brothers and sisters living: \_\_\_\_\_

- List any serious illnesses: \_\_\_\_\_

Number of brothers and sisters deceased: \_\_\_\_\_

- List ages and causes of death: \_\_\_\_\_

Are there any other diseases which tend to occur frequently in your family?  Y  N

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_