



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 Pulmonary and or Sleep 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 mail back to the office so that the Doctor can review and an appointment can be made.** If you have any question please call Rachel at the Scheduling Desk at 831-658-2187 (Option #2).

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.

Thank You,

Pulmonary: <ul style="list-style-type: none">• Georgina M. Heal, MD, FCCP• John M. Koostra, MD, FCCP• Hans P. Poggemeyer, MD, FCCP
Sleep: <ul style="list-style-type: none">• Richard J. Kanak, MD, FCCP, FAASM
Physician's Assistant: <ul style="list-style-type: none">• Larry Rose, PA
Nurse Practitioner: <ul style="list-style-type: none">• Joni Hoffman, FNP



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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: _____

DOB: _____ SSN#: _____

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: _____

New Patient Medical Questionnaire

Date:

Please complete the following questionnaire as completely as possible prior to your consultation with the Pulmonologist. Place a question mark next to anything you do not understand.

Name:

Address:

Fax #:

Home #:

Work #:

Other # (please specify):

Date of Birth:

Social Security #:

Email:

Who referred you to a Pulmonologist/Sleep Specialist? _____

What do you hope to achieve during this consultation? _____

Smoking History

Are you currently a cigarette, cigar or pipe smoker? Y N

If not a current smoker, have you smoked in past? Y N Quit date?

Maximum number of cigarettes smoked per day, **now or in past?**

How old were you when you started smoking?

Have you experienced any of the following? (Check all that apply)

IN THE PAST ONE YEAR:

- Persistent cough
- Sputum (phlegm)
- Coughing up blood
- Nosebleeds
- Shortness of breath:
 - *At rest*
 - *With exertion*
 - *While sleeping*
 - Lying flat
- Wheezing
- Chest pain or pressure
- Chills or fevers
- Heavy night sweats
- feet, ankle or leg swelling
- Weight loss or gain
- Trouble sleeping
- Restless legs

IN THE PAST ONE YEAR:

- Ear pain or plugging
- Hearing loss
- Nasal congestion
- Post-nasal drip
- Sneezing
- Sore throat
- Sinus pressure
- Sinus infection
- Morning headache
- Loud snoring
- Sleepy at work
- Sleepy while driving
- Forgetfulness
- Trouble concentrating
- Waking up unrefreshed
- Wake up choking
- Wake up with dry mouth

EVER:

- Blood clots in leg
- Blood clots in lung
- Nasal/sinus surgery
- Throat surgery
- Tuberculosis
- Valley fever
- COPD/emphysema
- Asthma
- Recurrent bronchitis
- Pulmonary fibrosis
- Pneumonia
- Sarcoidosis
- Cystic fibrosis
- Bronchiectasis
- Sleep apnea
- Depression
- Iron deficiency

List all childhood diseases you recall having:

- Whooping cough rheumatic fever polio chicken pox measles German measles
 mumps Other illnesses: _____

List all surgery you have had (lifelong):	List all nonsurgical hospitalizations:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Miscellaneous Medical Illnesses (Check all that you have now or had in the past)

- | | | |
|---|---|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> AIDS/HIV infection |
| <input type="checkbox"/> Seizure/Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bladder problems |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Internal bleeding | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Colitis | <input type="checkbox"/> Other kidney disease |
| <input type="checkbox"/> Heart valve problems | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> High cholesterol or
Triglycerides | <input type="checkbox"/> Cancer: What type? | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Diabetes
(elevated blood sugar) | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> glaucoma |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Gout |
| | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid disorder |

List any other medical problems not listed above.

List all prescription medicine, including inhalers, nasal sprays, topical medicine...

Name	Dosage	Name	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

List all vitamins, minerals, herbal/health supplements (e.g., Valerian)...

1.	5.
2.	6.
3.	7.
4.	8.

List any other non-prescription meds you take (e.g., Benadryl, Melatonin, Tylenol)...

1.	5.
2.	6.
3.	7.
4.	8.

List all medications you are allergic to or react badly to (and describe the reaction).

MEDICATION	REACTION

Did you ever have an x-ray test where dye (contrast) was injected into your vein? Yes No
If yes, describe any allergic reaction or side effects from the dye. _____

List all allergies to animals, plants, dust, food, etc... (Describe reactions) _____

Have you ever had allergy testing (skin testing)
Have you ever received allergy shots? (When?)

When and where did you get your last...
Flu shot (influenza vaccine)? _____
Pneumonia vaccine (Pneumovax)? _____
PPD (tuberculosis skin test)? _____
Chest x-ray? _____
Hepatitis vaccine? _____
Tetanus shot? _____
Any other adult vaccinations? _____

Are you: married separated divorced never married?
Who lives at home with you?

Where did you grow up? Where else have you lived and when?

How long have you lived locally?

What is your highest level of education/school attended?

What are your current and past occupations?

You are currently: self-employed an employee unemployed retired

What hazardous materials, fumes, dusts, chemicals, and etc have you been exposed to at work or associated within of your hobbies?

(e.g. exotic birds, bird feathers, grain dust, moldy hay, solder, asbestos, paint fumes, beryllium, welding, sand blasting, heavy metals, pesticides, baking flour dust)

List all travel outside the United States in the past 5 years.

Describe any military experience.

List any pets/animals you have at home, including birds, rodents, reptiles...

Describe your diet.

Do you drink...?

Beer Y N If yes, how much per day? _____ Days per week? _____
Wine Y N If yes, how much per day? _____ Days per week? _____
Liquor Y N If yes, how much per day? _____ Days per week? _____

Do you drink caffeinated beverages?

How much per day?

Coffee N Y _____
Tea N Y _____
Cola N Y _____

Do you think you might be at risk of HIV infection or AIDS? Y N

Have you ever been tested for HIV infection? Y N

- If yes, when? _____

Have you ever donated blood? Y N

- If yes, what is the most recent date? _____

Have you ever received a blood transfusion? Y N

- If yes, when? _____

Family Medical History

Please provide the following information about each family member, if known.

	Age	Still living?	Cause of death?	Primary health problems?
Father				
Mother				
Brother/Sister				
Children				

What hereditary diseases run in the family? (*To the best of your knowledge.*)

Check any of the following medical problems present in any family members.

- | | | | | |
|------------------------------------|---------------------------------------|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> High blood Pressure | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol |

General Review of Systems

What is your most recent: height _____ current weight _____ neck size _____

Weight at age 21? _____

Weight 1 year ago? _____

Weight 5 years ago? _____

Weight 10 years ago? _____

Have you experienced any of the following problems in the past 3 months?

(Check all that apply.)

Constitutional

- loss of appetite
- weight loss or gain
- chills or fevers
- heavy sweats at night
- easy fatigue
- daytime sleepiness

Ears, Nose, Mouth & Throat

- hearing loss or ringing in ears
- hoarse voice or sore throat
- loss of smell or taste
- mouth sores
- bleeding gums
- dentures or cavities

Skin

- rash, spots, bumps
- unusual itching
- change in hair
- change in finger/toenails

Neurologic

- dizziness
- recurring headaches
- trouble with balance or coordination
- fainting spells in the past 1-year
- seizures / epileptic fits
- memory loss
- weakness on one side of our body only

Musculoskeletal

- aches or pains
- muscle cramps
- swollen joints
- swollen ankles or feet

Eyes

- change or loss of vision

Endocrine

- pain, lump or discharge from breast
- extreme thirst or hunger
- excessive urination
- feeling hot all the time
- feeling cold all the time
- enlarged thyroid (goiter)
- loss of interest in sex
- impaired sexual performance

Gastrointestinal

- nausea or vomiting
- difficulty or pain swallowing
- belly pain or cramps
- heartburn or indigestion
- diarrhea or constipation
- vomiting blood
- blood in stool
- black or tarry stool
- yellow jaundice

Kidney, Bladder & Prostate (GU)

- difficulty, slow or painful urination
- waking up to urinate (if yes, how often?)
- poor bladder control
- bladder, kidney or prostate infection
- gonorrhea, syphilis, chlamydia, herpes

Cardiovascular

- chest pain
- chest pressure
- chest tightness
- palpitations
- skipped heart beats
- rapid or slow heartbeat
- heart murmur

Psychiatric

- feel sad or depressed
- recurring anxiety or nervousness
- hallucinations
- paranoid thoughts

Female/Reproductive (GYN)

- How many pregnancies?
- Miscarriages?
- Abortions?
- Are you still cycling? Y N
- Are cycles regular? Y N
- Any unusually prolonged or heavy bleeding
 Y N
- Have you undergone a hysterectomy? Y N
- At what age did you stop cycling? _____
- Date of last mammogram? _____
- Date of last PAP smear? _____

Hematologic/Lymphatic

- anemia
- swollen glands (lymph node)
- easy bruising or bleeding

Allergic/Immunologic

- immune system problem
 - serious or life-threatening allergic problem
- SPECIFY: _____

If you are unable to make your own medical decisions, who would you choose/have you chosen as a representative to speak for you?

(i.e. your durable power of attorney for healthcare)

Name:

Phone:

Relationship: