California Coastal Cardiology, PC

Dr. Robert W. Orr, M.D., F.A.C.C

Board Certified in Cardiovascular Disease

1235 W. Vista Way, Suite L • Vista, CA 92083

Phone: 760.630.1606 • Fax: 760.630.1654

Name: ____

First Middle Initial Last

Address: ____

Street Apt./Unit # City State Zip

Date of Birth: _____/_____/_____ **Circle One**: Male Female **Soc. Sec. #**: ______-____-______

Telephone: Hm. ( ) _____________ Wk. ( ) _____________ Cell ( ) _____________

Occupation: ______________ **Employer**: ___________________ **Employer's Tele**: ( ) _____________

Employer's Address: ____

Street City State Zip

Spouse's Name: _______________________________ **Spouse's Employer**: ____________________________

Person to contact in case of emergency:

Name: ____ **Relationship**: _________________________

Address: ____

Street City State Zip

Telephone: Hm. ( ) _____________ Wk. ( ) _____________ Cell ( ) _____________

Family and/or Referring Physician: ____

Insurance:

Please provide your insurance information card to our office personnel.

Patient's relationship to insured: Self: _______ Spouse: _______ Child: _______ Other: ______________

I authorize the release of any medical information to my insurance company necessary to process my insurance claims. I further authorize direct payment to California Coastal Cardiology, PC for any services rendered. I recognize and accept personal responsibility for any charges not covered by my insurance company.

Signature: ____ **Date**: _____/_____/_____

(If signed by patient representative, please state relationship)

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Patient Name: ____ Date of Birth: ______/______/______

Drug Allergies: ____

Medication List

Name of Medication	Directions	For what problem?

Hospitalization or Surgery

Date: Reason:

Date: Reason:

Date: Reason:

Date: Reason:

Medical History:

☐ Allergies/Hayfever	☐ Congenital Heart Disease	☐ GU Disorder	☐ Renal Disease
☐ Anemia	☐ Congestive Heart Failure	☐ Heart Murmur	☐ Rheumatic Fever
☐ Anxiety	☐ Diabetes	☐ Heart Palpitations	☐ Scarlet Fever
☐ Arrhythmia	☐ Dizziness/Fainting	☐ Hyperlipidemia	☐ Sexual Dysfunction
☐ Arthritis	☐ Endocrine Disease	☐ Hypertension	☐ Shortness of Breath
☐ Asthma	☐ Epilepsy	☐ Liver Disease	☐ Stroke/TIAs
☐ Claudication	☐ Fatigue	☐ Menstrual Dysfunction	☐ Ulcer
☐ Chest Pain/Angina	☐ GI Disorder	☐ MI	☐ Venereal Disease
☐ COPD	☐ Gout	☐ Orthopnea	☐ Other

Family History:	**Father**	**Mother**	**Father's Parents**	**Mother's Parents**	**Siblings**	**Children**
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

Habits:

☐Tobacco: Packs Daily: ____________ How Long: _____________ Interest in Stopping: _________________

☐Exercise routine: ____

☐Coffee: Number of Cups per Day: ____________ Other Caffeine: ____

☐Alcohol: Type: ________________________________ Amount: ____

☐Diet: Rate your salt intake: _________________________________ Fat intake: _________________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I have received a copy of this office's Notice of Privacy Practices.

____
(Please print your name)

____
(Signature)

____
(Date)

May we disclose your health information to a family member, friend or other person to the extent necessary to help with your health care?

____________________________________ Relationship: ______________________

____________________________________ Relationship: ______________________

____________________________________ Relationship: ______________________

Any restrictions on the information to be released?

____

____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We ale also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about your for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time; your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our

professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcard, or letters).

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expense such as copies and staff time. You may also request access by sending us a letter to the address at the end o this Notice. If you request copies, we may charge each page or per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associated disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once I a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency).

Alternative Communication: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should b amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on a website maintained by this office, or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have question or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Shellee Charles

Telephone: (760) 630-1606 Fax: (760) 630-1654 Address: 1235 W. Vista Way, Suite L, Vista, CA 92083