Santa Barbara Cardiovascular Medical Group, Inc.

Thomas Watson, M.D. • Sanjay Kumar, M.D. • Daniel Jurewitz, M.D.• Vishal Goyal, M.D. • Caleb Thompson, M.D.

Thank you for choosing Santa Barbara Cardiovascular for your healthcare needs. The Physicians and staff would like to take this opportunity to welcome you to our office.

For your convenience, we are providing a registration and other forms necessary to set up your medical file and bill your insurance.

ITEMS TO BRING WITH YOU:

****COMPLETED FORMS****
****INSURANCE CARD(S)****
****PHOTO PROOF OF IDENTIFICATION** (FTC Rule 16CFR§681)**
****MEDICATIONS LIST & DOSE** ***ALLERGIES*****
****MEDICAL RECORDS/LABS/TESTS** of value for your appointment**
****CO-PAY****
****ADVANCE DIRECTIVES** if you would like to have on file**

Please **ARRIVE EARLY** for your scheduled appointment. Your paperwork must be completed and additional authorization obtained prior to your scheduled appointment time. If you are unable to arrive early so that you can be seen on time, please call to reschedule your appointment.
You may be billed a fee for appointments missed and not rescheduled or cancelled 24 hours in advance.

APPOINTMENT DATE: _____ DAY: _____

OFFICE LOCATION ☐ 2400 Bath Street, Suite 201, Santa Barbara, CA
☐ 2050 Viborg, Santa Ynez Hospital Physician Clinic

CHECK IN TIME: _____ APPOINTMENT TIME: _____

Physician: _____

Do not hesitate to call the front desk with any appointment questions or directions to our office. We look forward to seeing you soon.

Sincerely,
Your Front Office Team

Revised 1/25/18

Santa Barbara Cardiovascular Medical Group, Inc.

2400 Bath Street, Ste 201 • Santa Barbara, CA 93105
Phone 805 682-7707 Fax 805 682-7710

PATIENT ACCOUNT #	DATE	RERERRED BY
NAME (LAST, FIRST, M.I.)		HOME TELEPHONE
ADDRESS	CITY	STATE / ZIP CODE
SOCIAL SECURITY NO.	DATE OF BIRTH / SEX M / F	MARITAL STATUS ☐SINGLE ☐ MARRIED ☐DIVORCED ☐WIDOWED
CELL #	YOUR EMPLOYER	WORK TELEPHONE
RACE* / ETHNICITY*	LANGUAGE* / PHARMACY	MY E-MAIL
PRIMARY CARE PHYSICIAN		PREFERRED METHOD FOR CONFIDENTIAL CONTACT *(appointment reminders will continue to be by phone)* ☐ PHONE ☐ CELL ☐ EMAIL ☐ PORTAL
SPOUSE'S NAME	SPOUSE'S EMPLOYER	
WHO SHOULD WE CALL IN CASE OF AN EMERGENCY?	RELATIONSHIP	TELEPHONE

2011 HEATH CARE REFORM REQUiRES US TO ASK QUESTIONS CONCERNING RACE, ETHNICITY & LANGUAGE. WE APOLOGIZE FOR THE INCONVENIENCE.

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE COPY OF INSURANCE CARD & DRIVER'S LICENSE

INSURANCE NAME & ADDRESS		
(INSURED) SUBSCRIBER	SUBSCRIBER #	GROUP NAME
GROUP NUMBER	INSURED DATE OF BIRTH	INSURED SOCIAL SECURITY NO.

SECONDARY INSURANCE INFORMATION

PLEASE PROVIDE COPY OF INSURANCE CARD & DRIVER'S LICENSE

INSURANCE NAME & ADDRESS		
(INSURED) SUBSCRIBER	SUBSCRIBER #	GROUP NAME
GROUP NUMBER	INSURED DATE OF BIRTH	INSURED SOCIAL SECURITY NO.

I hereby authorize all insurance benefits to be paid directly to SANTA BARBARA CARDIOVASCULAR MEDICAL GROUP. I understand that I am responsible for charges as designated by my insurance companies (e.g., deductibles, co-payments). I am also responsible for all charges not covered by insurance, and for any finance fees incurred on unpaid balances. I authorize SANTA BARBARA CARDIOVASCULAR MEDICAL GROUP to release information to my insurance companies when requested by them.

_____ _____

DATE SIGNED (insured or authorized)

SANTA BARBARA CARDIOVASCULAR MEDICAL GROUP
Health Questionnaire

Please be sure all information below is current and correct, then initial here: _____

Name: _____ DOB: _____ Age: _____ Date: _____

Phone: _____ Primary Care Physician: _____

1. PAST MEDICAL HISTORY

Have you ever had (circle answer):

Heart attack (myocardial infarction)..... Yes No
Angina pectoris ..... Yes No
Congestive heart failure ..... Yes No
High blood pressure ..... Yes No
High cholesterol ..... Yes No
Stroke (CVA, TIA) ..... Yes No
Phlebitis..... Yes No
Diabetes..... Yes No
Cancer (specify below)..... Yes No
Valley fever ..... Yes No
Anemia..... Yes No
Pneumonia..... Yes No
Ulcer disease ..... Yes No
Hepatitis ..... Yes No
Thyroid disorder ..... Yes No
Other chronic illnesses_____

_____

2. ALLERGIES

_____
_____
_____

3. MEDICATIONS & DOSAGES

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

4. SURGICAL HISTORY

Procedure Date or Age

_____
_____
_____
_____
_____
_____
_____

5. PERSONAL HISTORY

Birthplace _____
Have you ever lived outside the U.S. .....Yes No
Date last worked _____
How many cups of coffee do you drink daily _____
If you smoke, how much/how long _____
If you smoked, when did you quit _____
How many alcoholic drinks do you have daily _____
Do you exercise regularly .....Yes No
Activities: _____

_____

6. FAMILY HISTORY

Mother: Alive (age)_____ Deceased (age)_____
Cause of death: _____
Father: Alive (age) _____ Deceased (age)_____
Cause of death: _____
Brothers: Alive (age)_____ Deceased (age)_____
Cause of death: _____
Sisters: Alive (age)_____ Deceased (age)_____
Cause of death: _____
Relatives with (specify relation):
Heart disease _____
High blood pressure _____
Diabetes _____
Cancer _____
Tuberculosis _____

_____

7. DIETARY HISTORY

Do you restrict saturated fats & cholesterol .....Yes No
Do you restrict salt intake.....Yes No
Are you on a special diet.....Yes No
Explain: _____

8. HEAD, EYES, EARS, NOSE & THROAT

Frequent headaches.....Yes No
Do you wear glasses.....Yes No
Dizziness or fainting spells.....Yes No
Seizures or convulsions.....Yes No
Hard of hearing .....Yes No
Ringing in your ears .....Yes No
Sinus trouble or hay fever .....Yes No
Hoarseness of the voice .....Yes No
Trouble swallowing .....Yes No

_____
_____

NAME: _____ DOB: _____

9. HEART
- Heart murmur ..... Yes No
- High blood pressure ..... Yes No
- Palpitations/thumping/fluttering in chest ..... Yes No
- Chest pain/discomfort/tightness ..... Yes No
  - At rest ..... Yes No
  - With exertion ..... Yes No
- Swollen ankles ..... Yes No
- Leg pain with walking ..... Yes No
- How many pillows do you sleep on at night _____
- Have you ever had an angiogram, angioplasty or stent placement (specify below) ..... Yes No

_____
_____
_____
_____
_____

10. LUNGS
- Asthma ..... Yes No
- Frequent cough ..... Yes No
  - Productive (coughing up sputum) ..... Yes No
  - Dry ..... Yes No
- Have you ever coughed up blood ..... Yes No
- Shortness of breath/chest discomfort ..... Yes No
  - Worse with exertion ..... Yes No

_____
_____
_____

11. GASTROINTESTINAL
- Loss of appetite ..... Yes No
- Recent weight loss ..... Yes No
- Frequent nausea/vomiting ..... Yes No
- Abdominal pain ..... Yes No
- History of jaundice (yellow eyes/skin) ..... Yes No
- Excessive gas ..... Yes No
- Bloody or black stools ..... Yes No
- Frequent loose bowel movements ..... Yes No
- Chronic constipation ..... Yes No

_____
_____

12. GENITOURINARY
- How many times do you urinate at night _____
- Burning or pain with urination ..... Yes No
- Trouble starting or stopping urine stream ..... Yes No
- Loss of bladder control ..... Yes No
- History of blood in urine ..... Yes No
- History of urinary tract infections ..... Yes No
- History of kidney stones ..... Yes No

_____
_____

13. GYNECOLOGIC (women only)
- History of breast lumps or pain ..... Yes No
- Regular periods ..... Yes No
- Menopausal (periods stopped) ..... Yes No
- Last period: _____
- Hot flashes ..... Yes No
- Do you have regular PAP smears ..... Yes No
- Do you have regular mammograms ..... Yes No

_____
_____

14. BONES/JOINTS/MUSCLES/VASCULAR
- Do you have arthritis ..... Yes No
- Joints painful or swollen ..... Yes No
- Joint stiffness ..... Yes No
- Muscle aches/pains ..... Yes No
- Chronic back pain ..... Yes No
- History of fractures ..... Yes No
- History of varicose veins ..... Yes No

_____
_____

15. SKIN
- History of skin cancer ..... Yes No
- Skin rash or itching ..... Yes No
- Lumps or growths ..... Yes No

_____
_____

16. TRAUMATIC HISTORY
- History of trauma or serious injury ..... Yes No

_____
_____

17. GENERAL
- Difficulty falling or staying asleep ..... Yes No
- Average hours of sleep per night: _____
- Are you frequently ill ..... Yes No
- Are you considered a nervous person ..... Yes No
- Do you have fever, chills or night sweats ..... Yes No

_____
_____

18. OTHER SIGNIFICANT HEALTH INFORMATION

_____
_____
_____
_____
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_____
_____
_____
_____

Santa Barbara Cardiovascular Medical Group Inc.

Payment & Billing Disclosure and Agreement

Authorization to Bill Insurance•Assignment of Benefits•Authorization to Release Medical Records

To assist you in knowing what to expect from our billing policies, procedures, and communication with your insurance company, we are providing this document for your review. ***Since these are policies of SBCVMG, you may not change or alter any of the statements in any way.*** *Please feel free to contact our billing office should you have any questions.*

Payment is due at the time of service. As a courtesy, we will bill your insurance if we have the complete and correct information at the time of your visit. This includes, but is not limited to, your social security number. If we do not have the necessary information in order to bill your insurance, you will be responsible for the entire payment. Balances not paid promptly may be subject to a late payment fee.

I hereby assign Santa Barbara Cardiovascular Medical Group, Inc. (SBCVMG) all benefits and payments due from my medical insurance company/companies for services provided. In the event that my insurance does not cover services provided by SBCVMG, I agree and understand that the balance on my account, as indicated on the carrier's Explanation of Benefits, is my responsibility for payment.

Co-payments are expected at the time of service. Patients who do not have insurance will be expected to pay for their visit or make arrangements for payment at the time services are provided.

It is the responsibility of the patient to be informed of the inclusions and exclusions in their insurance policy including, but not limited to, co-pay and deductible amounts. It is the responsibility of the patient to promptly notify the office of changes in address and insurance information. Should I elect to have services provided by SBCVMG without proof of insurance, I understand and agree that I am fully responsible for complete payment of medical fees for services provided.

SBCVMG is not contracted with any HMO plans. If your insurance is an HMO (including Medicare HMO) and you choose to see a doctor at SBCVMG, you are expected to pay for your visit, in full, at the time of service. If you have MEDICARE as your primary insurance and an HMO as your secondary insurance, you will be responsible for the co-pay balance after Medicare pays.

SBCVMG is not contracted with all PPO's such as Health Net (except through MultiPlan.) SBCVMG will bill carrier, but we are under no obligation to accept their contracted amounts. The balance of your bill may be your responsibility. Please check your specific carrier for coverage.

If you have Santa Barbara IPA coverage, each visit and procedure must be authorized separately. You will not be seen without prior authorization. Unauthorized visits or procedures will be the responsibility of the patient.

If you need to miss an appointment, please call at least 24 hours in advance. Missed appointments without required advance notice may be billed at $50 for office visits, $100 for echos and $150 for Stress Echo.

If the Physician determines that laboratory, diagnostic testing, pharmaceuticals, or other ancillary charges or procedures are necessary for your treatment, I understand it is my responsibility, and not that of SBCVMG, to make sure that the provider of said charges accepts my insurance coverage.

I authorize the release of pertinent medical or other information necessary to process claims. I authorize SBCVMG to release my medical records, if required, to another physician or to my insurance company. A photocopy of this authorization is to be considered as valid as the original.

With my signature below, I acknowledge that I have read and accept all policies as described in this document.

Signature _____ Date _____

Santa Barbara Cardiovascular Medical Group, Inc.

Privacy Compliance Notice & Authorization

Patient medical and financial records are necessary to ensure that you receive the most accurate and timely treatment possible. Certain privileged information may also be required by your insurance carrier and to positively identify you for your own protection. Santa Barbara Cardiovascular maintains the highest level of locked and encrypted electronic security available, as well as strict adherence with the following laws:

The Privacy Act of 1974 (5 U.S.C. §552a)
Physician-patient Privilege (Evidence Code §994)
Patient's constitutional right of privacy (California Constitution Article 1, section 1)
Confidentiality of Medical Information Act (CMIA) (Civil Code §56 *et seq.*,)
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Professional Confidence (Business & Professions Code §2263)
California Civil Code Section 1798.85; 2001

Because there are some occasions for which you would like to <u>give permission to discuss information with specific individuals other than yourself</u>, we ask that you name and identify those persons below.

Name	Relationship

By signing below, I authorize my Physician or other authorized staff, to discuss my medical information as it pertains to prescriptions, lab results, procedures, testing, or treatment, when appropriate, with the named individuals. I understand that the Privacy Laws will continue to apply to all unauthorized individuals or entities. I understand that I may revoke any privilege, in writing, at any time.

Name (Print) _____ Date _____

Signed _____ ☐ Patient ☐ Guardian