NEWPORT PULMONARY ASSOCIATES
320 SUPERIOR AVE, SUITE 200
NEWPORT BEACH, CA 92663

DEAR PATIENT,

PLEASE DO NOT SEND THIS INFORMATION BACK TO OUR OFFICE. **BRING IT WITH YOU TO YOUR APPOINTMENT**. PLEASE HAVE IT FILLED OUT AHEAD OF TIME.

THANK YOU,

NEWPORT PULMONARY STAFF

NEWPORT PULMONARY ASSOCIATES MEDICAL GROUP

320 Superior Ave., Suite 200 · Newport Beach, CA 92663

Thomas Diamant, M.D. (G43620) · R. Bruce Moricca, M.D. (G49411) · Dennis R. Novak, M.D. (G29857) · Kashif Yaqub, M.D. (A125063)

PATIENT INFORMATION

NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____
STREET APT/UNIT

_____
CITY STATE ZIP CODE

HOME PHONE#: ( )_____ **CELL PHONE#:** ( ) _____
□ Preferred contact number □ Preferred contact number

□ **SINGLE** □**MARRIED** □**DIVORCED** □**WIDOWED** □ **DEPENDENT**

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

DRIVER LICENSE# _____ □Male □Female □Other

EMPLOYER: _____
BUSINESS NAME

_____
BUSINESS ADDRESS CITY/STATE/ZIP CODE

( ) _____ _____
BUSINESS PHONE OCCUPATION

PRIMARY INSURANCE CO: _____

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH: _____

ID#: _____ GROUP#: _____

SECONDARY INSURANCE CO: _____

INSURED'S NAME: _____ INSURED'S DATE OF BIRTH: _____

ID#: _____ GROUP#: _____

Pharmacy & location: _____

MEDICARE PART D: _____

ID#: _____

RX BIN#: _____ GROUP#: _____

REFERRED BY: _____

EMERGENCY CONTACT: _____

PHONE #: _____ RELATIONSHIP: _____

Who has the power of attorney for healthcare decisions?

Name: _____ **Advanced Directive** □ YES □NO

Authorization: I hereby authorize payment directly to NEWPORT PULMONARY ASSOCIATES MEDICAL GROUP and all insurance benefits, which may be due to me by me for services rendered by NEWPORT PULMONARY ASSOCIATES MEDICAL GROUP. I authorize release of any medical information necessary to process claims to my insurance company(s).

DATE: _____ **SIGNATURE:** _____

Newport Pulmonary Associates

Patient Assessment Questionnaire

Name: _____ Date: _____

DOB: _____ Age: _____

Referred by : _____

Reason for visit: _____

Immunizations: (List year of last injection or test)

Flu: _____ Pneumonia:_____ TB: _____ COVID: _____

Respiratory History: (Check those that apply)

Do you have a cough? ☐ No ☐In the morning ☐ All day long ☐ Dry cough ☐Congested cough

☐Wakes me up at night

Mucus: ☐None ☐Color: _____

Are you short of breath? ☐No ☐ All the time ☐With walking ☐With exercise ☐ With a cold

☐ Awakens me ☐Relieved with an inhaler

Do you wheeze? ☐ No ☐Yes ☐in AM ☐ Wheeze with exercise ☐ Daily ☐ Awakens me

☐ Relieved with inhaler

Do you have sinus congestion? ☐No ☐ Yes ☐Post-nasal Drip ☐Nasal Discharge
(color_____)

Do you snore? ☐No ☐Sometimes ☐Loudly

Have you or are you: ☐ Exposed to asbestos dust ☐Sawdust/dust ☐Farm dust

☐ Exposed to paint fumes ☐ Exposed to solvent fumes ☐ Exposed to plastics ☐ Exhaust fumes

Have you ever had: (check those that apply)

☐Pneumonia ☐Asthma ☐Recurring bronchitis ☐ Childhood Asthma ☐COPD ☐ TB ☐Sleep Apnea

☐ Lung Cancer ☐ Pleurisy ☐Valley Fever ☐Blood Clots ☐Pulmonary Embolism

☐Anesthesia intolerance ☐ Other: _____

Please list all physicians that you see: _____

_____

Name: _____ Date: _____

Past Medical History: (Check those that apply currently or in the past)

- ☐ Decreased Hearing
- ☐ Ringing in ear(s)
- ☐ Ear infections
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Blurred or double vision
- ☐ Eye infections
- ☐ Nose bleeds
- ☐ Sinusitis
- ☐ Hoarseness
- ☐ Sore throats
- ☐ Thyroid disease
- ☐ Chest Pain
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Heart Murmur
- ☐ Heart Palpitations
- ☐ Irregular Pulse
- ☐ Fainting spells
- ☐ Swollen ankles
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Difficulty swallowing
- ☐ Indigestion/heartburn
- ☐ Persistent nausea or vomiting
- ☐ Peptic ulcers
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Diverticulosis
- ☐ Blood in Stools
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Gallbladder trouble
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Urine infections
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Poor bladder control
- ☐ Prostate enlargement
- ☐ Kidney stones
- ☐ Anemia
- ☐ Immune deficiency
- ☐ Bruise easily
- ☐ Cancer
- ☐ Leg pain when walking
- ☐ Arthritis
- ☐ Gout
- ☐ Back Pain
- ☐ Bone fracture
- ☐ Joint injury
- ☐ Foot Pain
- ☐ Hayfever
- ☐ Rashes
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Allergies
- ☐ Chronic Fatigue
- ☐ Hairloss
- ☐ Seizures/convulsions
- ☐ Dizzy Spells
- ☐ Stroke
- ☐ Tremor
- ☐ Numbness
- ☐ Migraines
- ☐ Cold, numb feet
- ☐ Vericose veins
- ☐ Insomnia
- ☐ Drowsy
- ☐ Nervousness
- ☐ Depression
- ☐ Memory loss
- ☐ Mental illness
- ☐ Moodiness

Surgical History:

Surgery	Date	Surgery	Date

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____

Name: _____ Date: _____

Family History

Relative	Alive	Deceased	Age	Cause of death	High Blood Pressure	Heart Disease	Cancer	Diabetes	Asthma	COPD	Hayfever	Stroke	Anemia	Mental illness	Arthritis	Autoimmune disorder	Blood Clots
Father																	
Mother																	
Sister																	
Sister																	
Brother																	
Brother																	
Other																	

Social History

☐Single ☐Married _____ years ☐ Widowed ☐Life Partner ☐Divorced

Children: # of Daughters: _____ # of Sons: _____

Where were <u>you</u> born: _____

Where have <u>you</u> lived:

_____

Past & Present Occupations: _____

_____

Hobbies: _____

Pets: _____

Smoking history:☐ Never ☐ Yes-- Date Started: _____ Date Quit: _____

Type: ☐ Cigarettes (Avg. packs/day _____) ☐Cigars ☐Pipe ☐Marijuana ☐Other: _____

☐ **Second-hand smoke** (Years: _____)

Alcohol consumption ☐ No ☐ Yes: What_____ Amount: _____

Name: _____ **Date:** _____

Medical Allergies:

Medicine	Reaction

Misc. Allergies: ☐ Egg ☐Iodine ☐Shell fish ☐Other: _____

Current Prescription Medications (use back of page if needed):

Name	Dose	Frequency	Ordering MD

Supplements:

Name	Dose	Frequency	Ordering MD

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Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions, please call our office at (949)642-6200 prior to your appointment.

Insurance

Your health insurance is an agreement between you and your insurance company. As a courtesy, we will bill your insurance company and assist you by providing them with any information needed to process the claim.

We are "In Network" with most traditional PPO plans, but we suggest that you verify our participation in your specific network ***before*** making your appointment. Patients must understand their own network's plan benefits and plan limitations. There are many plans. It is not possible for us to know the specific details of each patient's coverage.

Making a copy of your insurance card does not confirm that we are part of your network. We always do our best, but failure of our office staff to identify out-of-network plans does not waive your responsibility for payment of services rendered. All charges are ultimately your responsibility, whether your insurance pays or not. Not all services are covered under all plans, regardless of whether our doctors consider the care medically necessary.

Patients are responsible for ensuring that our insurance records and other information (i.e. current address, phone number) are up to date. If your insurance changes, you must notify us immediately. Please bring your insurance card to every visit. Patients will have full responsibility for charges if we cannot process a claim due to incomplete, inaccurate or obsolete information. Delays caused by the patient can result in the claim being uncollectible from their insurance company, resulting in the patient having full responsibility for all charges.

Co-pays are always to be paid at the time of service. **Bills are due upon receipt**. We are required to collect co-pays, deductibles and co-insurance deductibles. Payments for outstanding patient balances are due within 30 days of the statement date. If it is necessary to assign your account to a collection agency and/or an attorney, you will be responsible for all collection agency fees, attorney fees, legal fees and court costs. Returned checks will be assessed a $25.00 fee.

As a courtesy, our office will make every effort to remind you of your appointments. It is ultimately the patient's responsibility to make sure they attend their appointment. Out of courtesy to other patients that need appointments, please notify our office if you need to cancel at least 24 hours prior to your appointment. ***Failure to notify our office for a missed appointment will result in a $50.00 charge.***

Office Fees

Extra forms and prior authorizations require time by our staff and physicians to complete and the items will be assessed a charge due prior to completion. Patients who participate in our **Patient Service Program** are exempt from these charges. The fee schedule for these services is posted in our waiting room.

It is understood that the undersigned, whether signing as an agent or as a patient, is financially responsible for services and accepts the terms described.

Patient Name: _____ **SIGNATURE:** _____
(Print please) (□ Patient □ Guardian/Guarantor □ Spouse)

Date of Birth: _____ **Date:** _____