MINIMALLY INVASIVE HEART & LUNG SURGERY
REGINALD G.M. ABRAHAM, MD, FACS, FACC, FCCP
11100 WARNER AVE., #258 FOUNTAIN VALLEY, CA 92708 Tel:714-549-5990 Fax: 714-845-0041

PATIENT INFORMATION

Name_____ Date of Birth_____
Last Name First Name

Soc Sec#_____ Sex: ☐M ☐F ☐Minor ☐Single ☐Married ☐_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ E-mail_____

Employer_____Business Phone_____

Business Address_____Occupation_____

EMERGENCY CONTACT INFORMATION

In case of emergency, who should we contact?

Name_____Phone_____Relationship_____

When it becomes necessary to contact you by phone, please list the number(s) where you wish us to call. May we leave messages, such as lab results, appointments or other medical information on am answering device, or with another person who answers the phone, at that number? Yes ( ) No ( )

Numbers(s): _____ _____

Name and phone number of emergency contact person NOT LIVING with you tel # _____

PAST MEDICAL INFORMATION:

Current Primary Care Physician_____Tel PCP:_____

Who can I thank for this refferal

Please indicate other Physicians you are currently seeing or have seen in the past 6 months:

Physician 1: _____ Physician 2: _____

Physician 3: _____ Physician 4: _____

MINIMALLY INVASIVE HEART & LUNG SURGERY
REGINALD G.M. ABRAHAM, MD, FACS, FACC, FCCP
11100 WARNER AVE., #258 FOUNTAIN VALLEY, CA 92708 Tel:714-549-5990 Fax: 714-845-0041

Please indicate any Testing that you have had in the past 6 months – include CT, MRI, PET, xrays, Angiogram, Cardiac Cath etc

TEST PERFORMED	LOCATION

INSURANCE INFORMATION

Person Responsible for Account_____Relationship to Patient_____

Birthdate_____Soc Sec #_____Employer_____

(1) Insurance Company_____Subscriber ID_____Group#_____

Person Responsible for Account_____Relationship to Patient_____

(2) Insurance Company_____Subscriber ID_____Group#_____

ASSIGNMENT & RELEASE

I hereby authorize payment directly to Dr. Reginald Abraham of all insurance benefits otherwise payable to me for the services rendered.

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider supplier of services in this office to release the information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____Date_____

Print Name_____

REGINALD ABRAHAM MD, FACS, FACC, FCCP

Less Invasive Heart and Lung Surgery

The experience you desire, the compassion you deserve

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

❤ Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

❤ Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him/her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

❤ Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

❤ Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____	_____	_____
Patient Signature	Date	Physician's or Authorized Representative's Signature

11000 Warner Ave, Ste 258, Fountain Valley CA 92708 Tel: 714-549-5990 Fax: 714-845-0041