Premier Heart and Vascular Center
Your Heart Matters

Premier Heart & Vascular Center

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ Age: _____ Male/Female

Mailing Address:_____

City: _____ State: _____ Zip: _____

Home:(_____) _____-_____Work: (_____) _____-_____ Cell: (_____) _____-_____

Social Security Number: _____-_____-_____

Patient's Email:_____

OK TO SEND STATEMENTS BY EMAIL _____y _____N

Spouse Name: _____Phone: _____

Emergency Contact (Local): _____

Phone #1: (_____) _____-_____ Phone #2: (_____)_____-_____

North/Second Address: _____

City: _____ State: _____ Zip: _____

Primary Care Doctor

(Local)Doctor_____

Office # _____ Fax # _____

(North) Doctor _____

Office # _____ Fax # _____

All services are payable at the time of service.

Patient/Guardian Signature: _____ Date: _____

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PATIENT ALLERGY AND MEDICATION LIST

Name:_____DOB:_____

Allergies:_____

Pharmacy: _____

Pharmacy Phone:_____

Medication	Dose	Frequency

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Name:_____Age:_____DOB:_____Date:_____

Past Medical History (please circle all that apply):

High blood pressure (Hypertension)
Low blood pressure (Hypotension)
Valve abnormality (repair/replacement surgery)
Pericarditis
Blockages in the coronary arteries
Heart attack
Congestive Heart Failure (CHF)
Cancer _____
Hepatitis or liver disease
History of blood clots in lungs (Pulmonary Embolism)
GERD (frequent heartburn)
COPD/Emphysema
Renal Artery Stenosis
Psychiatric illness (Anxiety, Depression, etc.)
Atrial Fibrillation (A-Fib) Atrial Flutter
Varicose Veins/ spider veins
Stroke or Transient Ischemia (TIA)
High Cholesterol/High Triglycerides
Abnormal EKG
Diabetes
Infection in the heart (Endocarditis)
Rheumatic fever/Rheumatic Heart Disease
Blood Clots in legs (DVT)
AIDS or HIV positive
Gout
Seizure Disorder
Thyroid problems
Heart Murmur
Carotid Artery Disease
Abdominal Aortic Aneurysm (AAA)
Peripheral Vascular disease (PVD)

Have you ever had the following tests/procedures :

	Date:		**Date:**
Stress Test (Treadmill, etc.)	_____	Tilt Table Test	_____
Holter Monitor	_____	Echocardiogram	_____
Event Monitor	_____	Carotid Ultrasound	_____
Electrophysiologic study (EPS)	_____	Peripheral Ultrasound	_____
Hearth Catheterization	_____	Coronary Angioplasty or Stent	_____
Varicose vein surgery	_____	Heart surgery	_____
Pacemaker	_____	Implantable defibrillator (ICD)	_____

Angioplasty or stenting in blood vessels other than your heart (e.g legs) _____

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Family History:

	Alive/ Deceased	Age	Present health or cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
	_____	_____	_____
Sister(s)	_____	_____	_____
	_____	_____	_____

Social History:

Occupation: _____ ( ) Retired

Are you married? ( ) yes ( ) no

Do you smoke or use tobacco now? ( ) yes ( ) no

Did you use tobacco in the past? ( ) yes ( ) no
(if so, complete below)
Packs per day: _____ Number of years:_____ ( ) Stopped When: _____

Do you use alcoholic beverages? ( ) yes ( ) no

If so, what type of alcohol and how frequent: _____

Other Surgeries_____

Allergies:

Do you have allergies to IODINE, seafood or radiographic contrast dye? ( ) yes ( ) no
Please list other allergies:

_____

_____

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Review of Systems (please circle all that apply):

Skips, irregular or abnormal heartbeat	Palpitations	Pain/discomfort in your chest, arms, throat
Pain in Jaw or upper back	Nose, mouth, or throat problems	
Hearing problem	Hearing aid	Visual disturbances
Recent fever or chills	Glaucoma	Sinus Problem
Breast disease	Cataracts	Dentures

Pulmonary:

Pneumonia	Bronchitis	Tuberculosis
Shortness of breath	Chronic Cough	Phlegm or sputum
Coughed up blood	Awaken at night with shortness of breath	
Shortness of breath with mild exertion		

Gastrointestinal:

Ulcer	Frequent indigestion or heartburn	Decreased appetite
Difficulty swallowing	Vomited blood	Abdominal pain
Passed blood from the rectum	Frequent nausea or vomiting	Pancreas problems
Frequent diarrhea	Constipation	
Changes in bowel habits	Significant change in weight	
Yellow jaundice	Gallbladder problems	

Musculoskeletal:

Joint pain	Swelling in your joints
Arthritis	Muscle pain, tenderness or swelling
Back pain	

Neuropsychiatric:

Significant head injury	Paralyzed
Headaches	Frequent dizziness/light headedness
Muscle weakness	Blackouts or fainting spells

Peripheral & Vascular:

Claudication (Dull, Cramping Pain in the Hips, Thighs, or Calf Muscle)
Open sores or ulcers on your legs or feet that won't heal
Leg pain when walking
Swelling of feet or ankles
Leg pain at rest
Hands or feet cold to the touch

Patient Statement:

To the best of my knowledge, the above information is accurate & complete.

Patient/Guardian Signature: _____Date:_____

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Payment Policy

Thank you for choosing us to care for your cardiology needs. We are committed to providing you with quality and affordable health care. It is important to us that you are aware of our financial policy and we are here for any questions you might have.

1. Insurance; We participate in most insurance plans, including Medicare. If you are insured by a plan we do business we can verify your coverage. Understanding your insurance benefits is important. Please contact your insurance company with any questions you may have regarding your coverage for services rendered by our physicians.

2. Co-payments and deductibles; All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. We accept all forms of payment for your convenience.

3. Non-covered services; Please be aware that some of the services you receive may be not covered or not considered reasonable or necessary by Medicare or other insurers. We will be diligent in making you aware if this is the case but is ultimately your responsibility to know what your plan will cover.

4. Claims submission;. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Our practice is committed to providing quality treatment to our patients. Our prices are representative of the usual and customary charges for our area.Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____/_____/_____

Signature of patient or responsible party/Date

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Notice of Privacy Practices Acknowledgement

____I acknowledge that I have received a copy of the Notice of Privacy Practices.

____I acknowledge that I have refused to accept a copy of the Notice of Privacy Practices.

Print Name:_____ Date:_____

Signature:_____

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Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred..

I have fully read and understand the above payment policy. I agree to forward to Premier Heart and Vascular center**, all insurance or third party payments that I receive for services rendered to me immediately upon receipt. Patient Initial: _____**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Relationship to Patient**

_____ _____

Printed Name of Witness Employee Job title

_____ _____

Signature of Witness Date