

CARDIOLOGY
CONSULTANTS, PC

PATIENT INFORMATION

___ William A Hill, Jr., M.D.
___ Jeffrey K. Anderson, M.D.
___ Amit K. Shah, M.D.
___ Edward A. Carraway, M.D.

___ John A. Mantle, M.D.
___ L. Anne Lewis, M.D.
___ J. Bradley Proctor, M.D.
___ Gregory Hamrick, C.R.N.P.
___ Caleb Elmore, C.R.N.P.

DATE: _____

ACCT. NUMBER: _____

Patient Name _____
(First) (Middle) (Last)

Date of birth: _____ Age: _____ Marital Status: Married/Single
(Circle)

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Phone Numbers: Home: _____ Cell: _____ Work: _____

E-mail: _____ Male or Female Social Security No: _____

Did another physician refer you here? Y / N Referring physician: _____

Who is your family physician? _____

Language: English / Spanish / Other Race: _____ Ethnicity: Nonhispanic / Hispanic
(Circle)

Employed: Y / N / Retired Employer: _____ Phone: _____

Spouse's Name: _____ Spouse's Employer: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective date: _____
Contract Number: _____ Group Number: _____
Insured Name: _____ Insured's Date of Birth: _____
Employer Plan? Y / N Employer: _____
Patient's relation to insured party: Self / Spouse / Parent / Child / Other Male / Female

Secondary Insurance Name: _____ Effective date: _____
Contract Number: _____ Group Number: _____
Insured Name: _____ Insured Date of Birth: _____
Employer Plan? Y / N Employer: _____
Patient's relation to insured party: Self / Spouse / Parent / Child / Other Male / Female

PLEASE HAVE YOUR DRIVER'S LICENSE AND ALL INSURANCE CARDS AVAILABLE FOR US TO SCAN. THANK YOU.

What is an alternate contact name and number of a person not living with you?

Name: _____ Phone: _____ Relation: _____

INSURANCE AUTHORIZATION

I hereby authorize Cardiology Consultants, P.C. to release any medical information needed by my insurance carriers in order to process my claim. I hereby authorize payments direct to Cardiology Consultants, PC. I understand that it is my responsibility to provide correct insurance information to Cardiology Consultants, P.C. I understand that my insurance may not pay the bill and that some of the services may be considered "noncovered" by my insurance contract. I understand that I will be responsible for the balance of my account. In the event of a returned check, I understand that a \$25.00 fee will be charged to my account at Cardiology Consultants, P.C.

Patient's Signature (Agreement to Pay) Date _____ Guarantor's Signature (Agreement to Pay) Date _____

Past Medical History

Please check and add details out to the side

Have you ever been told that you had:

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lipid disorder |
| <input type="checkbox"/> Aneurysm: abdominal <input type="checkbox"/> thoracic | <input type="checkbox"/> MI (heart attack) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Murmur |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> MVP (mitral valve prolapse) |
| <input type="checkbox"/> Atrial Flutter | <input type="checkbox"/> PAH (Pulmonary Artery Hypertension) |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> PUD (peptic ulcer disease) |
| <input type="checkbox"/> Claudication | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> PVD (peripheral vascular disease) |
| <input type="checkbox"/> Connective Tissue Disease (Lupus, Sarcoidosis, etc) | <input type="checkbox"/> Renal Failure <input type="checkbox"/> Insufficiency |
| <input type="checkbox"/> COPD (chronic obstructive pulmonary disease) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Rheumatic heart disease |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes (insulin or non-insulin dependent) | <input type="checkbox"/> SVT (supraventricular tachycardia) |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> TB (tuberculosis) |
| <input type="checkbox"/> Gastrointestinal Bleed | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Gastroesophageal reflux disease (GERD) | <input type="checkbox"/> TIA (transient ischemic attack) |
| <input type="checkbox"/> Heart block | <input type="checkbox"/> Valvular Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Ventricular Tachycardia |
| <input type="checkbox"/> Irregular heart rhythm | |

Surgical History

Please check and list date / facility / surgeon

- Abdominal Surgery _____
- Amputation: above knee
- Amputation: below knee
- Anesthesia Problems
- Aneurysm Repair
- Aortic Valve Repair Replacement
- Appendectomy
- Arteriogram carotid legs kidneys
- Bypass: Aorta-femoral left right
- Bypass: Fem-pop left right
- CABG (Open heart)
- Congenital heart surgery
- Endarterectomy Lt carotid Rt carotid
- EPS (Electrophysiology Study)
- Gallbladder surgery
- Heart Cath (dye test)
- ICD (Defibrillator) ICD : Bi-V
- Mitral Valve Repair Replacement
- Pacemaker
- PTCA (Angioplasty / stent) heart
- PTCA (Angioplasty / stent) leg kidney
- Stent Aorta Carotid Iliac
- Surgical Complications
- Thyroid surgery

Other operations _____

Patient Name: _____

Date: _____

Home Medications

List all medications & dosage you are presently taking and how frequently you take them:

Medication / Dose / Frequency

Please list all known allergies:

Family History

Please check and add any details out to the side

- Unknown [father, mother, sibling, grandparent]
- Aortic Aneurysm [father, mother, sibling, grandparent]
- Asthma [father, mother, sibling, grandparent]
- Bleeding Disorder [father, mother, sibling, grandparent]
- Cancer _____ [father, mother, sibling, grandparent]
- Congestive Heart Failure [father, mother, sibling, grandparent]
- Connective Tissue Disease [father, mother, sibling, grandparent]
- Coronary Artery Disease [father, mother, sibling, grandparent]
- Coronary Heart Disease-male < 55 [father, sibling, grandparent]
- Coronary Heart Disease-female < 55 [mother, sibling, grandparent]
- CVA or Stroke [father, mother, sibling, grandparent]
- Diabetes [father, mother, sibling, grandparent]
- Hyperlipidemia (cholesterol problems) [father, mother, sibling, grandparent]
- Hypertension [father, mother, sibling, grandparent]
- Marfan's Syndrome [father, mother, sibling, grandparent]
- PAH (Pulmonary Artery Hypertension) [father, mother, sibling, grandparent]
- Peripheral vascular disease [father, mother, sibling, grandparent]
- Prolonged QT [father, mother, sibling, grandparent]
- Renal Disease [father, mother, sibling, grandparent]
- Sudden Cardiac Death [father, mother, sibling, grandparent]
- Thyroid Disease [father, mother, sibling, grandparent]

Please circle family member(s) where applicable

Mother living? Yes No Age at death _____ Father living? Yes No
Age at death _____ Number of living brothers & sisters _____ Number of
deceased brothers & sisters _____

Social History

Marital Status: Single, Married, Divorced, Widowed

How many children do you have? _____

What is your occupation: _____

Disabled Retired

Smoking History:

Current Smoker: year started _____

Cigarettes: _____ packs per day

Cigars: _____ number per week

Smokeless: _____ amount per day

Counseled to quit or cut down: Yes No

Former smoker: year quit _____

Never smoked:

Passive smoke exposure Yes No

Do you drink alcoholic beverages? Yes No

Types of Alcohol? _____

How many drinks per day? _____

Drug Use? Yes No (If yes circle type below)

Marijuana, cocaine, crack, heroin, illicit prescription
Other _____

Do you drink caffeinated drinks? Yes No

How many per day? _____

Do you drink diet drinks? Yes No

Are you on a special diet? Yes No

- Calorie Limited Low Salt
- Low Fat Diabetic
- High Fiber Low Cholesterol
- Other _____

Do you exercise on a regular basis? Yes No

How many times per week? _____

Type of exercise? _____

Do you have a barrier to communication? Yes No
(If yes, circle impairment below)

Non-English Speaking Hearing Impairment
Vision Impairment

High Risk Behavior? Yes No

Comments: _____

Cardiology Consultants

Patient Name: _____ Date of Birth: _____ Date: _____

Review of Systems (please check if you have any of the following)

General

- Daytime sleepiness
- Weakness
- Weight Gain
- Weight Loss

Cardiovascular

- Chest pain
- Fainting
- Heart racing (palpitations)
- Swelling in feet/legs (peripheral)

Respiratory

- Cough
- Excessive snoring
- Shortness of breath
- Wheezing

Neurologic

- Dizziness (lightheadedness)
- Morning headaches

Gastro-Intestinal

- Constipation
- Diarrhea
- Bloody stools
- Indigestion
- Dark tarry stools
- Nausea
- Vomiting

Genital-Urinary

- Difficult urination (dysuria)
- Blood in urine (hematuria)

Musculo-Skeletal

- Leg pain
- Muscle cramps

Dermatologic

- Non-healing ulcer
- Scar to chest
- Scar to leg

Ears, Nose, Throat

- Hoarseness
- Nosebleed

Psychiatric

- Anxiety
- Depression

Allergies

- Allergic to dye
- Allergic to iodine
- Allergic to medications
- Allergic to shellfish

Form Completed By _____

Physician Signature _____

**CARDIOLOGY CONSULTANTS, PC
PATIENT CONTACT INFORMATION SHEET**

Patient Name: _____

Date of Birth: _____ **Social Security No:** XXX-XX-_____

Any physician, staff, employee or representative of Cardiology Consultants, PC, has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number (s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Cardiology Consultants, PC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individual(s).

Patient signature: _____ Date: _____



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Medication History Consent Authorization

By signing below, I hereby authorize Cardiology Consultants, P.C. to obtain my Medication History from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

Date of Authorization

Print Name

Date of Birth

Signature (Patient/Legal Representative or Parent/Legal Guardian)

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Cardiology Consultants, P.C. may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Pharmacy _____

Location _____