CARDIOLOGY CONSULTANTS, PC

___ 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.

PATIENT INFORMATION

___ L. Anne Lewis, M.D.
___ J. Bradley Proctor, M.D.
___ Gregory Hamrick, C.R.N.P.
___ Caleb Elmore, C.R.N.P.
___ Justin Sisk, C.R.N.P.

DATE: ____________________ **ACCT. NUMBER:** __________

Patient Name____________________________________ **Date of Birth:** ____________ **Age:**____________
(First) (Middle) (Last)

Marital Status: (circle one)

- Married
- Single
- Divorced
- Widowed
- Other

Gender Identity: (circle one)

- Male
- Female
- Female to Male
- Male to Female
- Choose not to disclose

Sexual Orientation: (circle one)

- Lesbian, gay, or homosexual
- Straight or heterosexual
- Bisexual
- Choose not to disclose

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

Phone Numbers: Home: ___________________ **Cell:** ___________________ **Work:** ___________________

E-mail: ______________________________________ **Social Security No:** ______________

Referring Physician: _____________________________ **Primary Care 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 $10.00 fee will be charged to my account at Cardiology Consultants, P.C.

______________________________ **Date** __________ ______________________________ **Date**__________
Patient's Signature (Agreement to Pay) *Guarantor's Signature (Agreement to Pay)*

Patient Name: ___________________________________ Date of Birth:_____________ Date: ________________________

Past Medical History

Please check and add details out to the side

Have you ever been told that you had:

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

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:

____
____
____

Do you have a living will or an advanced directive?

- ☐ Yes
- ☐ No
- ☐ Do not care to discuss

Family History

Please check and add any details out to the side — *Please circle family member(s) where applicable*

	Condition	Family member(s)
☐	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]

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: ______________________________

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