



Kettering Medical Center Physician Office Building
 3533 Southern Blvd., Suite 2100 – Kettering, OH 45429-1267
 (937) 293-3486 – Fax (937) 293-3605

8057 Washington Village Drive – Centerville, OH 45458-1847
 (937) 312-9890 – Fax (937) 312-9810

Calvert R. Busch, M.D., F.A.C.C.
 Harvey S. Hahn, M.D., F.A.C.C.
 Ziwar F. Karabatak, M.D., F.A.C.C., F.S.C.A.I.
 Robert W. Kiefaber, M.D., F.A.C.C., F.S.C.A.I.
 Brian P. Schwartz, M.D., F.A.C.C., F.S.C.A.I.
 David B. Stultz, M.D., F.A.C.C.

Todd Christie, PA-C
<http://www.swcardiology.com>

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: (____) _____ Cell Phone (____) _____
 Employer: _____ Work Phone (____) _____
 Social Security #: _____ Date of Birth: _____ Male Female
 Family Physician: _____ Referring Physician: _____

Emergency Contact

Name: _____ Relationship to Patient: _____
 Home Phone: (____) _____ Work Phone: (____) _____

Primary Insurance

Same as the patient information – patient is the Primary insurance subscriber
 Subscriber Name: _____ Subscriber Date of Birth: _____
 Subscriber Employer: _____ Subscriber Gender: Male Female

Secondary Insurance

Same as the patient information – patient is the Secondary insurance subscriber
 Subscriber Name: _____ Subscriber Date of Birth: _____
 Subscriber Employer: _____ Subscriber Gender: Male Female

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to Southwest Cardiology, Inc. to render needed treatment to the above named patient.
2. I authorize Southwest Cardiology Inc to release any Information required for payment of claims.
3. I authorize payment of medical benefits to Southwest Cardiology Inc for services rendered.
4. I understand that I AM RESPONSIBLE for all charges incurred through Southwest Cardiology, Inc. Payment is expected at the time of my visit. If this cannot be done, I agree to pay any collection or attorney's fees incurred above and beyond the past due amount.

Signature: _____ Date: _____



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Notice of Privacy Practices

Southwest Cardiology, Inc. patient acknowledgment:

I hereby acknowledge that I was given a copy of the Notice of Privacy Practices issued by Southwest Cardiology, Inc. on the date indicated below.

 Signature

 Print or Type Name

 Date

* Name of Patient (if different from above)

* Relationship to patient

 Witness signature

 Date

Authorization for Telephone Contact

Due to the number of patients who have voicemail and/or answering machines, we need information about how to communicate with you.

Do you have an answering machine at your home? Yes No

If yes, may we leave a message regarding test results, appointments, surgery scheduling and/or billing matters? Yes No

Phone number: _____

Do you have voicemail at your job? Yes No

If yes, may we leave a message for you to return our call? Yes No

Phone number: _____

If you are not available, may we leave the above information with the spouse, relative, or another person? Yes No

If yes, list the name and phone number below:

Spouse _____

Phone _____

Other _____

Phone _____

Other _____

Phone _____

Patient Signature

Date



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Background

Name _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____

Marital status: Married Divorced Widowed Single Other: _____

Retired Most Recent/Current Occupation: _____ Exercise: _____

Cardiac Risk Factors (Check all that apply)

Hypertension (high blood pressure) Diabetes High Cholesterol Overweight/Obesity

Tobacco (packs per day): Never <1/2 1/2-1 1-2 >2 Quit Smoking Date: _____

Alcohol (drinks per day): None <1 1-2 2-3 >3 Quit Alcohol Date: _____

Caffeine (drinks per day): None <1 1-2 2-4 >4

Personal Past Cardiac History (Check all that apply)

Coronary Artery Disease Myocardial Infarction (Heart Attack) Angina

Most Recent Heart Catheterization (Date & Hospital) _____

Coronary Stent (Dates) _____ Angioplasty (Dates) _____

Cardiac Bypass Surgery (Date) _____ Last Stress Test (Date/Place) _____

Congestive Heart Failure Last Hospitalization for Heart Failure (Date & Hospital) _____

Most Recent Echocardiogram (Date & Location): _____ Ejection Fraction: _____

Peripheral Vascular Disease Stroke Transient Ischemic Attack (Mini Stroke) Carotid artery disease

Abdominal Aortic Aneurysm Leg Claudication (Pain with walking)

Vascular Surgery (type, date, place) _____

Other: _____

Valvular Heart Disease Aortic Valve: Stenosis Regurgitation

Mitral Valve: Prolapse Regurgitation Stenosis Rheumatic Fever

Valve Surgery (Type of Valve, Date, Hospital): _____

Other: _____

Heart Rhythm Disorder Palpitations Atrial Fibrillation Atrial Flutter WPW

Heart Block Syncope (passing out) Pacemaker (Type, date) _____

Ablation Procedure (Type, Date & Hospital): _____

Other Cardiac Disease Myocarditis Pericarditis Pericardial Effusion Pulmonary Hypertension

Other: _____

Personal Past Medical History (Please check conditions currently treated or treated in the past)

- Lung disease:** Asthma COPD or emphysema Sarcoid disease
 Sleep Apnea CPAP use
- Neurologic diseases:** Migraine headaches Seizure disorder
- Liver disease:** Hepatitis Liver failure (cirrhosis) Gallstones
- Gastrointestinal disease:** Gastroesophageal reflux disease (heartburn) Peptic ulcer disease
 Chronic diarrhea Constipation Irritable bowel syndrome
- Kidney disease:** Renal failure Hemodialysis or Peritoneal dialysis
- Autoimmune disease:** Osteoarthritis Rheumatoid arthritis Lupus arthritis Scleroderma
 Immune deficiency (HIV, AIDS, or other)
- Hematologic disease:** Anemia Bleeding disorder
- Oncologic disease:** Cancer (type) _____
Cancer treatments: Chemotherapy Radiation Surgery
- Endocrine disease:** Thyroid disease Cushing's disease Addison's disease
- Ophthalmologic disease:** Glaucoma Cataracts Macular degeneration
- Psychiatric:** Depression Anxiety Other: _____

Other Personal Medical History

Personal Past Surgical history (Please list type of surgery, approximate year)

- Gallbladder _____ Appendix _____ Tonsils _____ Hernia _____

<i>Surgery</i>	<i>Year</i>	<i>Surgery</i>	<i>Year</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication Allergies: _____

Current Medications You may attach a separate list. Include herbal remedies, aspirin, and vitamin supplements.

<i>Medication</i>	<i>Dose</i>	<i>unit (mg)</i>	<i>How often</i>	<i>Comment</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family History (Please list immediate family members – parents, siblings, children)

	Deceased	Age (if deceased, age at death)	Heart attack	Heart Failure	Heart Bypass Surgery	Hypertension	Stroke	Other
Father	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of symptoms: Please check any symptoms you have had in the past 3 months

	Yes
General:	
Change in appetite	<input type="checkbox"/>
Persistent fever	<input type="checkbox"/>
General fatigue	<input type="checkbox"/>
General weakness	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>
Sensitivity to heat	<input type="checkbox"/>
Sensitivity to cold	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>
Depression	<input type="checkbox"/>

Eyes:	
Blurry vision	<input type="checkbox"/>
Loss of vision	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>

Ears, nose, mouth, throat:	
Loss of hearing	<input type="checkbox"/>
ringing in the ears	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>
Dentures	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>

Cardiovascular:	Yes
Chest pain or discomfort	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>
Fainting/loss of consciousness	<input type="checkbox"/>
Blue fingers or lips	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>

Respiratory:	
Shortness of breath	<input type="checkbox"/>
Persistent cough	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>
Pain with breathing	<input type="checkbox"/>
Short of breath laying down	<input type="checkbox"/>

Endocrine:	
Adrenal disease	<input type="checkbox"/>
Cortisone treatment	<input type="checkbox"/>

Genitourinary:	
Frequent daytime urination	<input type="checkbox"/>
Frequent nighttime urination	<input type="checkbox"/>
Pain or burning with urination	<input type="checkbox"/>
(men) erectile dysfunction	<input type="checkbox"/>

Nervous system:	
Headaches	<input type="checkbox"/>
Lightheadedness/dizziness	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>
Weakness or paralysis	<input type="checkbox"/>

Gastrointestinal:	Yes
Heartburn	<input type="checkbox"/>
Nausea	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>
Tarry stools	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>
Constipation	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>

Skin:	
Rash	<input type="checkbox"/>
Loss of pigmentation	<input type="checkbox"/>
Itching	<input type="checkbox"/>
Dry skin	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>
Skin Ulcers	<input type="checkbox"/>

Musculoskeletal:	
Muscle cramps	<input type="checkbox"/>
Pain in joints	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>

