



http://www.swcardiology.com

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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 Pneumonia
- Neurological diseases:** Migraine headaches Seizure disorder Neuropathy
- 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 Gout Rheumatoid arthritis Lupus arthritis Scleroderma
 Immune deficiency (HIV, AIDS, or other)
- Hematologic disease:** Anemia Bleeding disorder Deep vein thrombosis (DVT) Pulmonary embolus (PE)
- 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)

<input type="checkbox"/> Gallbladder _____	<input type="checkbox"/> Appendix _____	<input type="checkbox"/> Tonsils _____	<input type="checkbox"/> 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>How often</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

- | | | |
|--|---|---|
| <p><u>General:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 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 <p><u>Eyes:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Blurry vision <input type="checkbox"/> Loss of vision <input type="checkbox"/> Dry eyes <p><u>Ears, nose, mouth, throat:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 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 | <p><u>Cardiovascular:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 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 <p><u>Respiratory:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 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 <p><u>Endocrine:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Adrenal disease <input type="checkbox"/> Cortisone treatment <p><u>Genitourinary:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent daytime urination <input type="checkbox"/> Frequent nighttime urination <input type="checkbox"/> Pain or burning with urination <input type="checkbox"/> (men) erectile dysfunction <p><u>Nervous system:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Lightheadedness/dizziness <input type="checkbox"/> Memory loss <input type="checkbox"/> Weakness or paralysis | <p><u>Gastrointestinal:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 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 <p><u>Skin:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> 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 <p><u>Musculoskeletal:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Pain in joints <input type="checkbox"/> Swollen joints <input type="checkbox"/> Stiffness |
|--|---|---|



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Financial Policy

This Financial Policy has been established to clearly outline patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care while minimizing administrative costs.

- Patients who do not have insurance are expected to pay in full at the time of service unless prior arrangements have been made with us.
- Our office participates with numerous insurance companies and managed health care programs.
- It is the patient's responsibility to:
 1. Determine if our practice is in or out of their insurance network.
 2. Ensure that any required referrals for treatment are provided to the practice before the visit. Patients may be financially responsible if a required referral is not done.
 3. Know what pre-certifications may be required and ensure the requirements are met prior to the service.
 4. Provide us with current insurance information by presenting their insurance card(s) at each visit.
 5. Pay co-pays at the time of visit. An administrative charge of \$10.00 will be added if the co-pay is not paid at the time of your visit
- Payment for professional services can be made with cash, check, MasterCard or Visa.
- All returned checks will have a processing fee of \$35.00
- The office will submit a claim to your Primary and Secondary insurance, but the patient is ultimately responsible for the payment, regardless of insurance coverage. It is the patient's responsibility to submit Tertiary (Third) insurance claims. Please check with your insurance company for requirements.
- Our staff is happy to help with insurance questions regarding the processing of your claims. However, specific coverage issues can only be addressed by the insurance company's member services department whose number is on your card.
- All charges deemed patient responsibility by the patient's insurance shall be paid in full upon receipt of the first statement.
- It is the policy of Southwest Cardiology to provide a process for patients to meet their financial obligations to us. Please notify the receptionist if assistance is needed and you will be directed to the appropriate staff member.
- After review by the physician, patient balances aged 120 days on accounts with unfulfilled payment arrangements will be turned over to a collection agency and the patient will be discharged from the practice.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office. We are here to help you.

Please sign that you have read and agree to the SWC Financial Policy.

Signature

Print Name

Date



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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