MRN #: ______________________

LAST NAME: ______________________ FIRST NAME: ______________________ MIDDLE INITIAL: ____

ADDRESS: ____ CITY: _____________ STATE: _______

ZIP CODE: ___________ EMAIL: __________________________ PRIMARY PHONE: _________________

SECONDARY PHONE: _________________ OTHER CONTACT INFORMATION: _______________________

SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH: ____/____/____ (MONTH DAY YEAR) SSN: ___________________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED

IF MARRIED, SPOUSE'S NAME: ____ (FIRST NAME LAST NAME MIDDLE INITIAL)

PRIMARY CARE PHYSICIAN: ____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: ______________________ MEMBER INS. ID#: ____________________

GROUP #: ______________________ NAME OF INSURED IF OTHER THAN PATIENT: _________________

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURED DATE OF BIRTH: ____/____/____ (MONTH DAY YEAR) SSN: ___________________________

SECONDARY INSURANCE COMPANY: ______________________ MEMBER INS. ID#: ____________________

GROUP #: ______________________ NAME OF INSURED IF OTHER THAN PATIENT: _________________

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURED DATE OF BIRTH: ____/____/____ (MONTH DAY YEAR) SSN: ___________________________

PRINT NAME: ____

PATIENT SIGNATURE: ____ DATE: ____/____/____ (MONTH DAY YEAR)

DO WE HAVE PERMISSION TO:

- LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME?: ☐ YES ☐ NO
- LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT?: ☐ YES ☐ NO
- DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBERS OF YOUR HOUSEHOLD?: ☐ YES ☐ NO

IF YES, WHOM?: ______________________ RELATIONSHIP: ______________________

EMERGENCY CONTACT:

LAST NAME: ________________ FIRST NAME: ________________ MIDDLE INITIAL: ____

ADDRESS: ______________________________ CITY: __________ STATE: ______

ZIP CODE: ________ EMAIL: ____________________ PRIMARY PHONE: ____________

SECONDARY PHONE: ____________ OTHER CONTACT INFORMATION: ________________

HOW DID YOU HEAR ABOUT US?:

☐ DOCTOR REFERRAL
☐ FAMILY/FRIENDS/WORD OF MOUTH
☐ TELEVISION
☐ PLACE OF WORSHIP
☐ MAILER
☐ YELLOW PAGES
☐ COMMUNITY EVENT/HEALTH FAIR
☐ NEWSPAPER/MAGAZINE ADVERTISEMENT
☐ WEBSITE
☐ RADIO
☐ INTERNET SEARCH
☐ SOCIAL MEDIA
☐ HOSPITAL REFERRAL

WE ARE REQUIRED TO REQUEST THE FOLLOWING INFORMATION. THE FEDERAL ADMINISTRATIVE REPORTING AGENCY REQUESTS THAT WE PROVIDE THIS INFORMATION FOR STATISTICAL PURPOSES ONLY. YOUR PARTICIPATION IS OPTIONAL. PLEASE TAKE A MOMENT TO COMPLETE THE FOLLOWING QUESTIONS. THANK YOU. **IF YOU CHOOSE NOT TO PARTICIPATE PLEASE INITIAL HERE: ________

RACE:

☐ AMERICAN INDIAN
☐ PACIFIC ISLANDER
☐ ASIAN
☐ AFRICAN AMERICAN
☐ CAUCASIAN/WHITE

ETHNICITY:

☐ HISPANIC/LATINO
☐ NON HISPANIC

PREFERRED LANGUAGE:

☐ ENGLISH
☐ SPANISH
☐ ARABIC
☐ FRENCH
☐ OTHER

DATE OF LAST IMMUNIZATIONS:

LAST TETANUS: ________ / ________ (MONTH / YEAR)

FLU SHOT: ________ / ________ (MONTH / YEAR)

PNEUMONIA VACCINE: ________ / ________ (MONTH / YEAR)

DATE OF LAST PREVENTATIVE TEST:

COLONOSCOPY: ________ / ________ (MONTH / YEAR) NORMAL: Y/N

MAMMOGRAM: ________ / ________ (MONTH / YEAR) NORMAL: Y/N

PAP: ________ / ________ (MONTH / YEAR) NORMAL: Y/N

Medical History:

PLEASE CHECK ALL THAT APPLY:

- ☐ ANEURYSM
- ☐ ANXIETY
- ☐ ARTERY CLOT
- ☐ EMPHYSEMA
- ☐ ARTHRITIS
- ☐ ATRIAL FIBRILLATION/FLUTTER
- ☐ ASTHMA
- ☐ BLOOD OR CLOTTING DISORDER
- ☐ BLOOD IN URINE OR STOOL
- ☐ BRONCHITIS
- ☐ CANCER TYPE: ________
- ☐ CAROTID STENT
- ☐ CHEST PAIN
- ☐ COLITIS
- ☐ CONGESTIVE HEART FAILURE
- ☐ CORONARY ARTERY DISEASE
- ☐ COUGHING UP BLOOD
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DIARRHEA
- ☐ DRY EYES
- ☐ FAINTING SPELLS
- ☐ HEADACHE
- ☐ HEART ATTACK
- ☐ HEART BLOCKAGE
- ☐ HEARTBURN
- ☐ HEART MURMUR
- ☐ HEMODIALYSIS
- ☐ HEPATITIS
- ☐ HIATAL HERNIA
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV
- ☐ JOINT SWELLING
- ☐ KIDNEY ARTERY ANGIO/STENT
- ☐ KIDNEY CYST
- ☐ KIDNEY FAILURE
- ☐ KIDNEY STONES
- ☐ LEG OR ARM ANGIOPLASTY/STENT
- ☐ SLEEP APNEA
- ☐ LIVER DISEASE
- ☐ RHEMUATIC FEVER
- ☐ SEIZURES
- ☐ SHORTNESS OF BREATH
- ☐ SKIN RASH
- ☐ STOMACH ARTERY ANGIO/STENT
- ☐ STOMACH PAIN
- ☐ STROKE/CVA
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS
- ☐ URINARY ISSUES
- ☐ VALVULAR HEART DISEASE
- ☐ VISION LOSS
- ☐ VISION BLURRY/DOUBLE VISION

PLEASE LIST AND OTHERS BELOW:

____

____

____

____

____

Allergies:

DO YOU HAVE ANY ALLERGIES TO DRUGS, FOOD LATEX OR DYE? YES / NO
IF SO PLEASE LIST BELOW:

ALLERGY:	REACTION:
______________________________	____
______________________________	____
______________________________	____
	____
	____
	____
	____
	____
	____
	____

Surgery & Procedure History:

- ☐ AICD/DIFIBRILLATOR
- ☐ CORONARY ANGIOPLASTY
- ☐ HEART VALVE SURGERY
- ☐ KNEE AORTIC ANEURSYM REPAIR
- ☐ CORONARY ARTERY BYPASS
- ☐ HERNIA
- ☐ LAP BAND APPENDECTOMY
- ☐ CORONARY REVASCULARIZATION
- ☐ HEMORRHOIDECTOMY
- ☐ MASTECTOMY BACK
- ☐ EP STUDY
- ☐ HIP REPLACEMENT
- ☐ PACEMAKER IMPLANT CARDIAC CATH
- ☐ GALLBLADDER
- ☐ HOMOGRAFT REPLACEMENT
- ☐ PROSTATE CARDIOMYOPLASTY
- ☐ GASTRIC BYPASS
- ☐ HYSTERECTOMY
- ☐ RF ABLATIONS CARDIOVERISON
- ☐ HEART TRANSPLANT
- ☐ ICD LEAD EXTRACTION
- ☐ SLEEP APNEA SURGERY

PLEASE LIST OTHER RELATIVE PROCEDURES & HISTORY BELOW:

____
____
____
____
____
____
____
____
____
____
____

Family History:

	DECEASED (D)? ALIVE (A)? / AGE	MEDICAL CONDITION?
FATHER		
PATERNAL GRANDFATHER		
PATERNAL GRANDMOTHER		
MOTHER		
MATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER		

HOW MANY ? BROTHER(S) ____________ SISTER(S) ____________ HEALTHY? Y/N

SON(S) ____________ DAUGHTER(S) ____________ HEALTHY? Y/N

Social History:

SMOKING/TOBACCO USE: YES / NO IF YES, HOW MANY YEARS: ______ PACKS PER DAY: ______

FORMER SMOKER/TOBACCO USE: YES / NO IF YES, HOW LONG AGO ______ PACKS PER DAY: ______

ALCOHOL USE: YES / NO IF YES, HOW OFTEN:

☐ MONTHLY OR LESS ☐ 2-4 TIMES A MONTH ☐ 2-3 TIMES WEEKLY ☐ 4 OR MORE TIMES WEEKLY

HOW MANY DO YOU TYPICALLY CONSUME WHEN DRINKING?: ____________________________________

SUBSTANCE USE: YES / NO IF YES, HOW OFTEN: ☐ YEARLY OR LESS ☐ MONTHLY OR LESS

☐2-4 TIMES MONTHLY ☐ 2-3 TIMES WEEKLY ☐ 4 OR MORE TIMES WEEKLY

WHAT KIND: ____

Social History Cont'd:

CAFFEINATED BEVERAGES: YES / NO IF YES, HOW OFTEN: ☐ 1-2 CUPS DAILY ☐ 2-3 CUPS DAILY ☐ 3-4 CUPS DAILY ☐ 4 OR MORE CUPS DAILY

DIET: YES / NO IF YES, WHAT KIND: ☐ VEGETARIAN ☐ LOW FAT ☐ PALEO ☐ DAIRY FREE ☐ VEGAN ☐ OTHER: ______________________________

EXERCISE: YES / NO IF YES, HOW OFTEN: ☐ 1-2 TIMES WEEKLY ☐ 2-3 TIMES WEEKLY ☐ 4 OR MORE TIMES WEEKLY

WHAT TYPE: ______________________________

Current Medications:

NAME:	DOSAGE:	HOW OFTEN:

PHARMACY LOCATION & PHONE NUMBER: ______________________ ( ) _ _ _ - _ _ _ _

Acknowledgement of Receipt of Privacy Notice:

WE ARE REQUIRED BY LAW TO OFFER YOU A COPY OF OUR NOTICE OF PRIVACY PRACTICES. TO ENSURE THAT OUR RECORDS ARE ACCURATE, PLEASE SIGN THIS FORM AND RETURN IT TO OUR RECEPTIONIST TO ACKNOWLEDGE THAT YOU HAVE BEEN OFFERED A COPY OF OUR NOTICE.

ASSIGNMENT OF BENEFITS:

I HEREBY ASSIGN TO ANSAARIE CARDIAC & ENDOVASCULAR COE ANY INSURANCE OR OTHER THIRD-PARTY BENEFITS AVAILABLE FOR HEALTHCARE SERVICES PROVIDED TO ME. I UNDERSTAND THAT ANSAARIE CARDIAC & ENDOVASCULAR COE HAS THE RIGHT TO REFUSE OR ACCEPT ASSIGNMENT OF SUCH BENEFITS. IF THESE BENEFITS ARE NOT ASSIGNED TO ANSAARIE CARDIAC & ENDOVASCULAR COE I AGREE TO FORWARD THE PRACTICE ALL HEALTH INSURANCE AND OTHER THIRD-PARTY PAYMENTS I RECEIVE FOR SERVICES RENDERED TO ME IMMEDIATELY UPON RECEIPT.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO DETERMINE THESE BENEFITS PAYABLE FOR THE RELATED EQUIPMENT OR SERVICES TO THE ORGANIZATION, THE HEALTH CARE FINANCING ADMINISTRATION, MY INSURANCE CARRIER OR OTHER MEDICAL ENTITY. A COPY OF THIS AUTHORIZATION WILL BE SENT TO THE HEALTH CARE FINANCING ADMINISTRATION, MY INSURANCE COMPANY OR OTHER ENTITY IF REQUESTED. THE ORIGINAL WILL BE KEPT ON FILE BY THE ORGANIZATION.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ORGANIZATION FOR ANY CHARGES NOT COVERED BY HEALTH CARE BENEFITS. IT IS MY RESPONSIBILITY TO NOTIFY THE ORGANIZATION OF ANY CHANGES IN MY HEALTH CARE COVERAGE. IN SOME CASES, EXACT INSURANCE BENEFITS CANNOT BE DETERMINED UNTIL THE INSURANCE COMPANY RECEIVES THE CLAIM. I AM RESPONSIBLE FOR THE ENTIRE BILL OR BALANCE OF THE BILL AS DETERMINED BY THE ORGANIZATION AND/OR MY HEALTH CARE INSURER IF THE SUBMITTED CLAIMS OR ANY PART OF THEM ARE DENIED FOR PAYMENT. I UNDERSTAND THAT BY SIGNING THIS FORM I AM ACCEPTING FINANCIAL RESPONSIBILITY AS EXPLAINED ABOVE FOR ALL PAYMENT FOR PRODUCTS RECEIVED.

BY SIGNING THIS DOCUMENT, I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE ORGANIZATIONS NOTICE OF PRIVACY PRACTICES. THIS ACKNOWLEDGEMENT IS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) TO ENSURE THAT I HAVE BEEN MADE KNOWN OF MY PRIVACY RIGHTS.

RELEASE OF RECORDS:

THIS LETTER CERTIFIES THAT I GIVE PERMISSION TO RELEASE COPIES OF MY PERSONAL MEDICAL RECORDS FROM
______________________ FOR TREATMENT RENDERED AT THE OFFICE, TO:

NAME OF PERSON SIGNING (PRINT NAME): ______________________________

RELATIONSHIP TO INSURED: ______________________________

PATIENT DATE OF BIRTH: ______________________________

SIGNATURE OF INSURED OR PARENT/GUARDIAN: ______________________________

DATE: ____________________

Patient Care Team:

WE WANT TO BE ABLE TO WORK CLOSELY WITH ALL OF YOUR DOCTORS TO HAVE CONTINUITY OF CARE AND BEST SERVE YOU AND YOUR HEALTH NEEDS, SO PLEASE GIVE US THE NAME OF EACH SPECIALIST YOU SEE.

SPECIALTY NAME:	NAME OF PHYSICIAN:	PHONE #:	ALT PHONE #:
ALLERGIST			
CARDIOLOGIST			
ENDOCRINOLOGIST			
ENT			
GASTROENTEROLOGIST			
GENERAL SURGEON			
OB/GYN			
HEMATOLOGIST			
INFECTIOUS DISEASE			
NEPHROLOGIST			
NEUROLOGIST			
OPHTHALMOLOGIST			
OPTOMETRIST			
PAIN MANAGEMENT			
PODIATRIST			
PSYCHIATRIST			
PULMONOLOGIST			
RHEUMATOLOGIST			
UROLOGIST			