ANSAARIE
CARDIAC & ENDOVASCULAR
CENTER OF EXCELLENCE

PATIENT INFORMATION

Last Name: _____ First Name:_____ Middle Initial: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Email: _____ Primary Phone: _____ Secondary Phone: _____

Sex: ❑ Male ❑ Female Date of Birth:_____/_____/_____SSN:_____
Month Day Year

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

If Married, Spouse's Name: _____
First Name Last Name Middle Initial

Primary Care Physician: _____

Pharmacy: _____ Phone Number: _____

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: _____

Primary Emergency Contact:

Last Name: _____ First Name:_____Primary Phone: _____

Preferred Language: ❑ English ❑ Spanish ❑ Arabic ❑ French ❑ Other_____

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:_____/_____/_____SSN:_____
Month Day Year

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: _____/_____/_____SSN: _____
Month Day Year

CURRENT MEDICATIONS

Name:	Dosage:	How Often:

ALLERGIES

Do you have any allergies to medications, foods, or other? Please list in the space below

Allergy:	Reaction:

PAST MEDICAL HISTORY

Please check all that apply:

- ❑ Aneurysm
- ❑ Anxiety
- ❑ Artery Clot
- ❑ Emphysema
- ❑ Arthritis
- ❑ Atrial Fibrillation/Flutter
- ❑ Asthma
- ❑ Blood Or Clotting Disorder
- ❑ Cancer Type:
- ❑ Carotid Stent
- ❑ Chest Pain
- ❑ Congestive Heart Failure
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ Fainting Spells
- ❑ Headache
- ❑ Heart Attack
- ❑ Heart Blockage
- ❑ Heartburn
- ❑ Heart Murmur
- ❑ Hemodialysis
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV
- ❑ Kidney Artery Angio/Stent
- ❑ Kidney Failure
- ❑ Leg Or Arm Angioplasty/Stent
- ❑ Sleep Apnea
- ❑ Liver Disease
- ❑ Seizures
- ❑ Shortness Of Breath
- ❑ Skin Rash
- ❑ Stomach Artery Angio/Stent
- ❑ Stroke/CVA
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Valvular Heart Disease
- ❑ Vision Loss
- ❑ Vision Blurry/Double Vision

Please List Others Below:

_____

_____

_____

_____

SURGERY & PROCEDURE HISTORY

- ❑ AICD//Defibrillator
- ❑ Coronary Angioplasty
- ❑ Heart Valve Surgery
- ❑ Aortic Aneursym Repair
- ❑ Coronary Artery Bypass
- ❑ Hernia Repair
- ❑ Gastric Bypass
- ❑ Coronary Revascularization
- ❑ Hemorrhoidectomy
- ❑ Mastectomy
- ❑ EP Study/Ablation
- ❑ Hip/Knee Replacement
- ❑ Pacemaker Implant
- ❑ Gall Bladder
- ❑ Prostate
- ❑ Hysterectomy
- ❑ Cardioverison
- ❑ Heart Transplant
- ❑ Sleep Apnea Surgery

Please list other relative surgeries and/or procedures below:

_____

_____

_____

_____

FAMILY HISTORY

	Deceased Y/N? If yes what age?	Medical Condition?
Father		
Mother		
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		

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 beverages do you typically consume when drinking? _____

Substance Use: Yes / No If Yes, How Often:

❑ Yearly or Less ❑ Monthly ❑ 2-4 Times Monthly ❑ 2-3 Times Weekly ❑ 4 or More Times Weekly

What Kind: _____

Caffeinated Beverages: Yes / No If yes, how many cups daily? _____

ACKNOWLEDGEMENT OF RECIEPT 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: _____