******PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT******

Name _____ Date _____

Local Address_____

City _____State_____ Zip_____

Home Phone_____ Cell_____ Work_____

Preferred Contact Number: Home _____ Cell _____ Work _____ Other _____

Northern Address/ Phone Number_____

_____

Email_____ Gender: Male Female Transgender

Race/Ethnicity_____ Language _____

Date of Birth _____ Marital Status: Single Married Widowed Divorced

Primary Care Physician_____

Social Security _____ Employer Name_____

In Case of Emergency: Name _____

Phone Number_____ Relationship_____

Primary Insurance_____ ID#_____

Secondary Insurance_____ ID#_____

Pharmacy _____ Phone #_____

Name of Spouse (Only needed if Insurance is in spouse's name): _____

Spouse's Date of Birth_____ Spouse's Social Security _____

How did you hear about our office? _____

Patient Signature_____ Date _____

ASSIGNMENT AND RELEASE

The Non-Medicare Patient

I hereby assign to Cardiology Consultants of Southwest Florida any and all benefits from any insurance plans or any other protection maintained by the Patient and/or for the Patient's behalf or benefit and authorize and direct such benefits to be paid directly to Cardiology Consultants of Southwest Florida for services provided to the patient by Cardiology Consultants of Southwest Florida. I certify that the information given by me to Cardiology Consultants of Southwest Florida in applying for payment under Medicare and/or Medicaid programs, insurance plans, or other protection is correct and complete. I authorize the release of all records required to act on this release and assignment.

The Medicare Patient

I request that payment of authorized Medicare benefits be made to me or on my behalf to Cardiology Consultants of Southwest Florida for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to Cardiology Consultants of Southwest Florida in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original.

FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa, MasterCard, American Express and Discover.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor-in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment or co-insurance at the time of your visit.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

I have read and understand this policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

Patient Name _____ Date _____

Signature _____ Witness _____

Notice of Privacy Practices

We are required to provide you with our "Notice of Privacy Practices" upon request. Please notify the receptionist if you would like a copy.

Please provide the information below:

Your Name (please print) _____

Date of Birth _____

I give Cardiology Consultants permission to obtain my medical records from any outside source for the purpose of providing my medical care.

Signature: _____ Date: _____

Do you give permission to discuss your medical and financial information with family members and/or friends?

Yes _____ No _____

If yes, please list the friends/family members that you would like to authorize us to speak to:

Name Relationship Phone Number

- _____
- _____
- _____
- _____

The "Notice of Privacy Practices" was made available to me.

Your Signature_____ Date _____

Current Medications List

Name: _____ **Date:** _____

Prescription Medications, Over the Counter Medications, Supplements, Herbs:

Name of Medication	Strength/Dose	Frequency/Times per Day

MEDICAL HISTORY

Name: _____ **DOB**:_____

Referring Physician:_____

Reason for visit:_____

Patient Medical History:

Diabetes	**no**	**yes**
Hypertension	**no**	**yes**
Hyperlipidemia	**no**	**yes**
Cancer	**no**	**yes**
Stroke	**no**	**yes**
Heart Trouble	**no**	**yes**
Arthritis/ Gout	**no**	**yes**
Hepatitis	**no**	**yes**
HIV/AIDS	**no**	**yes**
Varicose Veins	**no**	**yes**

Allergies:

_____

_____

Previous Surgeries:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Social History:

Occupation:_____ **Retired: YES**_____ **NO** _____

Alcohol Use: Type _____ **Frequency**_____ **Years**_____

Tobacco Use: Type_____ **Packs per day**_____ **years**_____ **Quit date**_____

Caffeine Use: Type_____ **How many cups per day?** _____

Recreational Drug Use: YES NO Type_____

Exercise: Type _____ ____ **How many times per week?**_____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Grandfather Maternal:	_____	_____	_____
Paternal:	_____	_____	_____
Grandmother Maternal:	_____	_____	_____
Paternal:	_____	_____	_____

	How many?	Diseases/If Deceased, Cause of Death
Brothers:	____	_____
Sisters:	____	_____
Sons:	____	_____
Daughters:	____	_____

CARDIOLOGY CONSULTANTS

Please Check All That Apply:

Constitution:
- □ Weight Gain
- □ Loss of Appetite
- □ Night Sweats
- □ Weakness
- □ Weight Loss

Peripheral Vascular:
- □ Varicose Veins
- □ Spider Veins
- □ Leg Pain
- □ Leg Swelling
- □ Ulceration
- □ Heaviness
- □ Leg Tiredness
- □ Leg Heaviness
- □ Restless Legs
- □ Itching or Burning
- □ **Are you interested in treating these symptoms? □ Yes □ No**

ENT:
- □ Cough
- □ Coughing Blood
- □ Snoring

Ophthalmology:
- □ Diminished Vision
- □ Blurring of Vision
- □ Vision Loss
- □ Wear Contacts
- □ Wear Glasses

Endocrinology:
- □ Fatigue
- □ Excessive Sweating
- □ Weight Loss
- □ Sleep Disturbance
- □ Cold Intolerance
- □ Hives

Cardiology:
- □ Chest Pain
  - □ Substernal
  - □ With Exertion
  - □ At Rest
  - □ Radiating to Back/Arm/Jaw
  - □ Relieved with Nitroglycerin
- □ Palpitations
- □ Leg Swelling
- □ Dizziness / lightheadedness
- □ Shortness of Breath

Respiratory:
- □ Shortness of Breath
- □ Chest Congestion

Gastroenterology:
- □ Nausea
- □ Heartburn
- □ Vomiting
- □ Bloating/Belching
- □ Abdominal Pain
- □ Diarrhea
- □ Constipation
- □ Blood in Stool/Dark Stool

Neurology:
- □ Headache
- □ Tingling/Numbness
- □ Seizures
- □ Dizziness
- □ Memory Loss
- □ Gait Abnormality

Musculoskeletal:
- □ Joint Swelling
- □ Joint Pain
- □ Leg Cramps
- □ Joint Stiffness

Patient Signature:_____ **Date:** _____

CARDIOLOGY CONSULTANTS

Missed Appointment and Cancellation Policy

As a courtesy, please contact our office at least 24 hours in advance if you are unable to keep your scheduled appointment, to ensure that you will not be charged for the appointment.

There will be a $35 fee for all missed appointments and a $100 fee for all missed diagnostic tests and procedures without 24-hour notice.

New patients will be charged $50 for a missed appointment without at least 24-hour notice.

Patient Name: _____Date: _____

Signature: _____

Thank you for your consideration