



ASSOCIATES IN
CARDIOVASCULAR
DISEASE

PATIENT NAME: _____ DATE OF BIRTH: _____ AICD PHYSICIAN: _____
PRIMARY CARE PHYSICIAN: _____ E MAIL: _____ PHONE: _____ CELL #: _____
EMERGENCY CONTACT NAME AND PHONE: _____
PHARMACY NAME/LOCATION: _____ MAIL AWAY PHARMACY: _____

RISKS

Tobacco	Dyslipidemia (High cholesterol)	Hypertension (High blood pressure)
___Y___N___Former ___Year quit	___Y___N___Unknown	___Y___N___Unknown
Type: _____Packs/day	Type: _____Cholesterol	___Year diagnosed
___Cigarette:s ___Chew ___Years smoked	___Triglycerides	Peripheral Vascular Disease
___Cigar ___Pipe	___Cholesterol & triglycerides	___Y___N___Unknown
___Smokeless	___Low LDL	
Diabetes	Family History of Heart Disease	
___Y___N ___Type 1 ___Type 2	___Y___N___Unknown ___Adopted	
___Year diagnosed		

SOCIAL HISTORY

Marital status: ___M___D___S___W Children ___Y___N # ___Daughters # ___Sons Race: _____	Lifestyle Diet: ___Regular ___Low fat, low cholesterol ___Low salt ___Diabetic	Exercise ___Sedentary ___Occasional ___Regular ___Active lifestyle ___Physically unable to exercise
Tobacco ___Y___N___ ___Year quit ___Rarely/never ___Frequently ___Socially ___Daily	Alcohol ___Y___N___Former Year quit _____ ___Daily___Rarely___Socially	Drug Use ___Y___N___Former Year quit _____ Type of drug abused: _____ Frequency of drug use: ___Daily ___Occasionally
Personal Advance Directives: ___None ___DNR ___Living Will Primary Language: _____ Religion: _____	Caffeine ___None___Coffee___Tea___Soda Education: ___None___Elementary level___High school___GED___College___Post college	
Employment/Occupation: Employer: _____ Occupation: _____ Phone: _____ ___Full time ___Part time___Self employed___Retired___Active Military___Disabled___Unemployed___Child		
Patient name: _____ Date of birth: _____ Date: _____		

FAMILY HISTORY

(Include parents, siblings, maternal and paternal grandparents, aunts and uncles) * Use second sheet of paper if necessary.

Family Member	Name	Age of onset or death	Pertinent family history Include the following: Heart disease, cardiac surgery, hypertension, diabetes, sudden death, stroke, cancer, high cholesterol, emphysema, aneurysms, Alzheimer's, multiple sclerosis, alcohol and drug abuse

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING:

CHECK ONLY IF APPLICABLE AND IF CHECKED PLEASE INCLUDE THE YEAR

<u>EYES, EAR S, NOSE AND THROAT</u>	<u>YEAR</u>	<u>RESPIRATORY</u>	<u>YEAR</u>	<u>CARDIOLOGY</u>	<u>YEAR</u>
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Arrhythmias	_____
<input type="checkbox"/> Diabetic retinopathy	_____	<input type="checkbox"/> Chronic bronchitis	_____	<input type="checkbox"/> Cardiomyopathy	_____
<input type="checkbox"/> Macular degeneration	_____	<input type="checkbox"/> COPD	_____	<input type="checkbox"/> Congestive heart failure	_____
<input type="checkbox"/> Retinal detachment	_____	<input type="checkbox"/> Emphysema	_____	<input type="checkbox"/> Heart attack	_____
<input type="checkbox"/> Other _____	_____	<input type="checkbox"/> Lung cancer	_____	<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> None of the above	_____	<input type="checkbox"/> Pneumonia	_____	<input type="checkbox"/> High blood pressure	_____
		<input type="checkbox"/> Pulmonary embolism	_____	<input type="checkbox"/> Valve disease	_____
		<input type="checkbox"/> Sleep apnea	_____	<input type="checkbox"/> Cardiac bypass	_____
		<input type="checkbox"/> TB	_____	<input type="checkbox"/> Cardiac stent/angioplasty	_____
		<input type="checkbox"/> Other _____	_____	<input type="checkbox"/> Implantable defibrillator	_____
		<input type="checkbox"/> None of the above	_____	<input type="checkbox"/> Pacemaker	_____
				<input type="checkbox"/> Valve replacement	_____
				<input type="checkbox"/> Cardiac catheterization	_____
				<input type="checkbox"/> Other _____	_____
				<input type="checkbox"/> None of the above	_____

Patient name: _____

Date of birth: _____

Date: _____

VASCULAR

- ___ Abdominal _____
- ___ carotid artery disease/carotid surgery _____
- ___ Claudication (leg pain while walking) _____
- ___ DVT (deep vein thrombosis) _____
- ___ PVD (peripheral vascular disease) _____
- ___ Phlebitis _____
- ___ Raynaud's _____
- ___ Varicose veins/vein stripping _____
- ___ Amputation _____
- ___ Other _____
- ___ None of the above _____

YEAR

GENITOURINARY

- ___ Bladder cancer _____
- ___ Enlarged prostate _____
- ___ Chronic kidney failure _____
- ___ Erectile dysfunction _____
- ___ Blood in urine _____
- ___ Kidney stone _____
- ___ Treatment for kidney stone _____
- ___ Prostate cancer _____
- ___ Urinary tract infections _____
- ___ Other _____
- ___ None of the above _____

YEAR

MUSCULOSKELETAL

- ___ Back pain **YEAR** _____
- ___ Carpal Tunnel _____
- ___ Fibromyalgia _____
- ___ Gout _____
- ___ Herniated disk _____
- ___ Lupus _____
- ___ Arthritis _____
- ___ Rotator cuff tear _____
- ___ Sciatica _____
- ___ Spinal stenosis _____
- ___ Back surgery _____
- ___ Elbow surgery (R) (L) _____
- ___ Knee replacement surgery (R)(L) _____
- ___ Hip replacement surgery (R)(L) _____
- ___ Rotator cuff repair _____
- ___ Other _____
- ___ None of the above _____

GASTROINTESTINAL

- ___ c Difficile infection _____
- ___ Gall bladder disease/surgery _____
- ___ Cirrohsis _____
- ___ Crohn's Disease _____
- ___ Diverticulitis _____
- ___ Diverticulosis _____
- ___ GERD (Reflux) _____
- ___ Hepatitis _____
- ___ Hiatal hernia _____
- ___ Pancreatitis _____
- ___ Peptic ulcer _____
- ___ Bowel obstruction _____
- ___ Ulcerative colitis _____
- ___ Appendectomy _____
- ___ Gastric bypass _____
- ___ Other _____
- ___ None of the above _____

YEAR

OB/GYNECOLOGICAL

- ___ Benign breast lumps _____
- ___ Breast biopsy _____
- ___ Breast cancer (R) (L) _____
- ___ Mastectomy (R) (L) _____
- ___ Breast augmentation _____
- ___ Cervical cancer _____
- ___ Endometriosis _____
- ___ Ovarian cancer _____
- ___ Tubal ligation _____
- ___ D&C _____
- ___ Hysterectomy _____
- ___ Other _____
- ___ None of the above _____

YEAR

SKIN

- ___ Cellulitis **YEAR** _____
- ___ Hives _____
- ___ Psoriasis _____
- ___ Eczema _____
- ___ Scleroderma _____
- ___ Shingles _____
- ___ Skin cancer _____
- ___ Other _____
- ___ None of the above _____

Patient name: _____

Date of birth: _____

Date: _____

NEUROLOGICAL

- __ALS _____
- __Alzheimer's _____
- __Positional vertigo _____
- __Dementia _____
- __Diabetic neuropathy _____
- __Multiple sclerosis _____
- __Migraines _____
- __Myasthenia gravis _____
- __Parkinson's Disease _____
- __Seizure disorder _____
- __TIA _____
- __Fainting/Nearly fainting _____
- __Other _____
- __None of the above _____

YEAR

ENDOCRINE

- __Diabetes _____
- __Goiter _____
- __High calcium _____
- __Hyperthyroid _____
- __Hyperparathyroid _____
- __Hypothyroid _____
- __Obesity _____
- __Pituitary tumor _____
- __Thyroidectomy _____
- __Other _____
- __None of the above _____

YEAR

ONCOLOGY

- __Bladder cancer _____
- __Breast cancer _____
- __Colon cancer _____
- __Glioblastoma _____
- __Leukemia _____
- __Liver cancer _____
- __Lung cancer _____
- __Lymphoma _____
- __Prostate cancer _____
- __Other _____
- __None of the above _____

YEAR

PSYCHIATRIC

- __Alcoholism _____
- __Bipolar disorder _____
- __Anxiety _____
- __Eating disorder _____
- __Depression _____
- __Obsessive compulsive disorder _____
- __Panic disorder _____
- __Post traumatic stress disorder _____
- __Schizophrenia _____
- __Other _____
- __None of the above _____

YEAR

HEMATOLOGICAL (BLOOD)

- __Anemia _____
- __Ever had a blood transfusion? _____
- __Bone marrow transplant _____
- __Coagulation difficulties _____
- __Sickle cell anemia _____
- __Factor V Leiden _____
- __Other _____
- __None of the above _____

YEAR

List ALL surgery/injuries/hospitaliz

YEAR

1. _____
2. _____
3. _____
4. _____
5. _____

INFECTIOUS DISEASE

- __Endocarditis _____
- __Herpes _____
- __HIV/AIDS _____
- __Lyme Disease _____
- __Other _____
- __None of the above _____

YEAR

Below please add any information you want included

Additional information: _____

FINANCIAL POLICY STATEMENT

To help our patients fully understand our billing process, we ask that you read and sign our financial policy statement.

As a courtesy to you, Associates in Cardiovascular Disease will submit a claim to your insurance carrier. Depending upon your individual policy, your coverage, your deductible and/or co-payment requirements, you may be billed for the balance.

Although Associates in Cardiovascular Disease participates with most insurance carriers, ***it is your responsibility*** at the time of service to verify with your insurance carrier if the particular physician or the service/test that you are scheduled to have is accepted by your plan.

For claims not submitted as a courtesy, AICD accepts cash, checks, debit cards, MasterCard or Visa for payment. For insurance plans that do not allow courtesy submission of claims, you must pay at the time of service.

When our doctor participates fully in your insurance plan, you are still responsible for paying any co-insurance, deductible or co-payment(s) as indicated by your carrier, as well as any non-covered service(s) under their contract. Once payment has been made or payment has been denied by the insurance company you will be billed and be responsible to pay the balance.

You are responsible for bringing the necessary referral(s) to the office on the day of your appointment. If you do not have the required referral form(s) on the day of the appointment, you are responsible for payment at the time of service and must sign a waiver.

Although Associates in Cardiovascular Disease may on occasion, as a courtesy to you, file private insurance claims, we will not become involved in disputes between, you and your insurance carrier regarding covered charges, secondary insurance issues or “usual and customary” charges other than supply factual information as requested by the insurance carrier.

THANK YOU FOR TAKING THE TIME TO REVIEW THE ASSOCIATES IN CARDIOVASCULAR DISEASE FINANCIAL POLICY STATEMENT. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS, COMMENTS OR SPECIAL CONCERNS!

Responsible Party Signature: _____ Date: _____

PRINT NAME: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE
AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Privacy Practice Notice

I have received a copy of the Associates in Cardiovascular Disease's Notice of Privacy Practices. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Associates in Cardiovascular Disease, LLC for purposes of treatment, payment or healthcare operations. I understand that my protected health information may be used for such purposes without my written authorization.

Print Patient's Name

Date of Birth

Signature of Patient/Parent/Guardian

Date

- Check here if you do not wish voice messages to be left on your answering machine or voicemail.

Daytime phone number: _____

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Associates in Cardiovascular Disease (AICD) may disclose certain documents regarding my health information to a family member, close personal friend or other caregiver because such a person is involved with my health care.

I designate the person(s) listed below as individual(s) involved with my health care provided by AICD for the purpose of making the disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request to AICD.

Print Name: _____ Relationship: _____ Date of Birth: _____

Print Name: _____ Relationship: _____ Date of Birth: _____

Print Name: _____ Relationship: _____ Date of Birth: _____

Signature of Patient/Parent/Guardian

Date