ADVANCED HEART & VASCULAR CARE

DEMOGRAPHICS **Instructions: Please fill out as completely as possible. All information will be kept confidential.**

LAST NAME	FIRST NAME	MIDDLE	DATE OF BIRTH	SEX	AGE

ADDRESS (NUMBER AND STREET)	HOME PHONE

CITY	STATE	ZIP CODE	CELL PHONE

EMAIL	SOCIAL SECURITY NUMBER	MARITAL STATUS

OCCUPATION	EMPLOYER	BUSINESS PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP

SPOUSE'S NAME	SPOUSE'S BIRTHDAY	SPOUSE'S NUMBER

EMERGENCY CONTACT INFORMATION

LAST NAME	FIRST NAME	PHONE NUMBER

RELATIONSHIP	DATE OF BIRTH	OTHER NUMBER

INSURANCE & OTHER INFORMATION

PRIMARY PHYSICIAN: _____

REFERRING PHYSICIAN (IF NOT PRIMARY): _____

PHARMACY: _____

PRIMARY INSURANCE: _____

POLICY HOLDER'S NAME AND BIRTHDAY : _____

SECONDARY INSURANCE: _____

POLICY HOLDER'S NAME AND BIRTHDAY : _____

PATIENT AUTHORIZATION TO BILL INSURANCE

In order to submit a claim for services rendered, your authorization is needed for the release of medical information to your insurance company. I hereby authorize ADVANCED HEART & VASCULAR CARE to submit claims to my insurance for services rendered by them or through them, and to release all necessary medical information in order to obtain payment. If services rendered are not covered by my insurance company I agree to pay for those services, or any balance left over after claims are fulfilled unless otherwise contracted through my insurance company and Advanced Heart & Vascular Care.

_____ _____

Patient's Signature Date

MEDICAL INFORMATION

PATIENT NAME	DATE OF BIRTH	TODAY'S DATE

Do you smoke or have you in the past? _____ # of years_____ Packs per day _____

ILLNESSES OR MEDICAL PROBLEMS – please put " ✓" in the box if you have had					
ILLNESSES	✓	ILLNESSES	✓	ILLNESSES	✓
Chest Pain/Pressure		Stroke		Ankle Swelling	
Shortness of Breath		Heart Murmur		Asthma	
High Blood Pressure		Rheumatic fever		Blood Clots	
Heart Attack		Palpitations		Emphysema	
Catheterization/Stent		High Cholesterol		Fatigue/tired	
Cardiac Bypass		Diabetes		Heartburn	
Vomiting		Syncope/Dizziness			

Other heart conditions: _____

Other illnesses doctor should be aware of:_____

FAMILY ILLNESSES OR MEDICAL PROBLEMS – please put " ✓" in the box if it applies					
	DIABETES	HEART DISEASE	HIGH BLOOD PRESSURE	KIDNEY DISEASE	STROKE
Father					
Mother					
Brother					
Sister					
Paternal Grandparents					
Maternal Grandparents					

ALLERGIES	
SUBSTANCE	REACTION

HOSPITALIZATION- don't include normal pregnancies		
YEAR	OPERATION OR ILLNESS	HOSPITAL AND CITY

HIPAA Acknowledgement

I have read the foregoing Notice of Privacy Practices provided to me by Advanced Heart & Vascular Care, and I have been given the opportunity to discuss their privacy practices. I understand that Advanced Heart & Vascular Care may, at its discretion, change the terms and conditions of this notice. Any questions I may have had have been answered to my satisfaction. I understand the content of the Notice of Privacy Practices and I have been provided with a copy of the same.

_____ _____ _____
Print Name Signature Date

For Staff Members Only
The Notice of Privacy Practices was provided to _____, however patient didn't acknowledge receipt for the following reason:Refused Didn't Understand Other:(_____)

_____ _____
Staff Signature Date

Authorization for Disclosure of Protected Health Information (PHI)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I wish to be contacted in the following manner (check all that apply)**:**

Oral Communication:

- **OK** to call my **work** phone number? Yes:☐ No:☐
- **OK** to leave a message with detailed information on my **work** phone number? Yes:☐ No:☐
- **OK** to leave a message with detailed information on my **home/cell** phone number? Yes:☐ No:☐
- **OK** to leave a message with a call back number? Yes:☐ No:☐

Written Communication:

- **OK** to mail to **home** address? Yes:☐ No:☐
- **OK** to mail to **work** address? Yes:☐ No:☐
- **OK** to **fax** to this number: Yes:☐ No:☐
  Fax number: _____

I permit Advanced Heart & Vascular Care to discuss and disclose my PHI with the following individuals:

My spouse: _____ Contact Number: _____

My child: _____ Contact Number: _____

Personal Representative:_____ Contact Number: _____

Other: _____ Contact Number: _____

Please list any additional instructions that may apply: _____

_____ _____
Patient's Signature Date