Registration Form

Date_____

_____ _____ ___ _____ ____ _____

Patient last name **First name** **MI** **Date of birth** **Age** **Male/Female**

_____

Street address **City** **State** **Zip**

_____-_____-_____ _____ _____

Social Security Number **Home phone** **Cell phone**

_____ **Marital Status:** **single married divorced widow**

Email Address ***do not have*** □

Race: □ Asian (Indian) □ Pacific □ Black/African Amer. □ White □ Hispanic □ Native American □ Other

Ethnicity: □ Hispanic/Latino □ NOT Hispanic/Latino □ Refuse to Report

Language:□ English □ Spanish □ Indian □ Other _____

_____ _____ _____

Emergency First/Last Name **Relationship** **Phone Number**

_____ _____

Primary care doctor (full name) **Doctor's phone number**

_____

Doctor's Address / City

_____ _____ _____

Pharmacy Name **City** **Pharmacy Phone#**

Insurance Information

Name of Policy#1_____Whose policy? □ Self □ Spouse □ Father or Mother

If insurance is in another person's name, please provide:_____ _____

Insured's name Insured's DOB

Name of Policy#2_____Whose policy? □ Self □ Spouse □ Father or Mother

If insurance is in another person's name, please provide:_____ _____

Insured's name Insured's DOB

AUTHORIZATION AND ASSIGNMENT

BLANKET AUTHORIZATIONS: I understand that the following authorizations are to be used by 247 Heart & Vascular Specialists, Management and Care and ALL PHYSICIANS associated therewith to affect the collections of benefits on my behalf. These authorizations become effective on the date of the first service rendered in my behalf and remain in effect until specifically revoked in writing by me. Copies of this agreement will be as valid as this original.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize payment directly to 247 Heart & Vascular to Physicians associated therewith, of the benefits payable under all plans of health insurance otherwise payable to me but not to exceed the physician's regular charges for periods of treatment. I further understand that I am financially responsible for payments of charges not covered by this authorization.

DEFINITION OF PRIOR AGREEMENT: (For Blue Shield Patient Only) For U.R.C. purpose "Prior Agreement" means that an advance mutual understanding has been created between Physician and Patient to the effect that a) the Blue Shield Payment will probably be less than the Physician's charge for the services, and b) that the patient will be responsible for the difference.

MEDICARE: I authorize payment of Medicare/PMD/Medigap/Medicaid/ Government benefits to be made to 247 Heart & Vascular and physicians associated therewith for any services furnished me by the physician. Charges not covered by Medicare/PMD/Medigap/Medicaid/Government benefits include services rejected by deductible and/or co-pay. I understand I will be responsible for these non-covered charges and that payment for these charges is due at the time service is rendered. Authorization is given to file Medigap claim if applicable.

LEGAL/COLLECTION FEE: I agree to pay ALL reasonable fees of attorneys and/or collection agencies needed to affect collection of any delinquent charges outstanding on my account. I also authorize my billing records to be released for this purpose.

HIPAA PATIENT CONSENT FORM

As part of your health care, it is necessary to create, maintain and (in certain situations) share medical information concerning your health history and current health care services to carry out treatment, payment and health care operations. You are giving authorization to all hospitals ,physicians, medical facilities, clinics, and health insurance companies to get medical records and/or information.
Quest Diagnostics- You are giving authorization for genetic testing (plavix resistance test Cytochrome P450 2C19) in order for medical management for anticoagulant therapy for CAD.

Patient/Sign here:_____ DATE OF BIRTH: _____

SIGNATURE (Patient or responsible person if patient is a minor or unable to sign)

MEDICAL HISTORY

The reason for this visit is: _____

□Cardiac Evaluation □ Chest pain □ Shortness of Breath □ Palpitations □ Dizziness □Fatigue

□ Surgical Clearance
Surgeon/Date/Procedure_____

Height: _____ **Weight:_____**

SEE ATTACHED RX LIST □ *hospital list* □ *copied list* □ *None*

Medication	Dosage	Schedule

Do you have any type of allergies? □No □Yes

If Yes, Please specify: _____

Surgical History- Date:_____

_____**N/A□**

Hospitalizations- Date: _____

_____**N/A□**

Medical Condition	Self ✓	Family Member	Mother/Father Side
Aneurysm			
Arrhythmia			
Atrial Fibrillation			
Cardiac Arrest			
Coronary Artery Disease (CAD)			
Carotid Stenosis (plaque)			
Diabetes- I or II			
Digestive Problems (GERD)			
Heart Attack			
Heart Failure (CHF)			
High Blood Pressure- HTN			
High Cholesterol			
Kidney Disease (Renal)			
Stroke (CVA)			
Thyroid (hypo or hyper)			
Varicose Veins			
Other			

Father:□Alive □Deceased
□Stroke □ Heart disease □Dementia □ Cancer □Diabetes Other _____

Mother:□Alive □Deceased
□Stroke □ Heart disease □Dementia □ Cancer □Diabetes Other _____

Do you smoke:
□Yes □No How much?_____

Do you use alcohol:
□Yes □No How much?_____