Saline Heart Group, P.A.

Account # _____
Date _____

Patient Information

In order for us to provide you with the best possible care, please fill out these forms as completely and accurately as possible.

Last Name: _____ First Name: _____ Middle Initial: ____
Mailing Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
☐ Physical address is the same as mailing address
Physical Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Cell Phone #: _____ Home Phone #: _____
Email Address: _____

Date of Birth: _____ Age: _____ Social Security #: _____
Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Spouse's Name: _____ Phone #: _____
Spouse's Employer: _____ Work Phone #: _____

Education: ☐ High School ☐ Associate Degree ☐ College ☐ Post Graduate
Race: ☐ Caucasian/White ☐ Black American ☐ American Indian ☐ Asian
Ethnic Group: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

Employer Information

Occupation: _____
Employer: _____ Work Phone #: _____

In Case of Emergency

Name: _____ Relationship: _____
Phone #: _____ Work Phone #: _____

Name: _____ Relationship: _____
Phone #: _____ Work Phone #: _____

Primary Care Physician: _____ Phone #: _____

Saline Heart Group, P.A.

Account # _____

Insurance Information

Please give your insurance card & ID to the receptionist

Primary Insurance Carrier: _____ Phone #: _____
Policy #: _____ Group #: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____ Subscriber's Soc. Sec. #: _____
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance Carrier: _____ Phone #: _____
Policy #: _____ Group #: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____ Subscriber's Soc. Sec. #: _____
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Payment Information

Person Responsible for Bill: _____
Relationship to the patient: _____
Address (if different): _____
City: _____ State: _____ Zip Code: _____

Insurance Authorization

I authorize the release of medical information necessary to process the insurance claim(s). I authorize and direct my insurance carrier or intermediaries to issue payment check(s) directly to Saline Heart Group.

I understand that my insurance company may require an authorization number, precertification, and/or referral. Without this documentation, I understand that my insurance company may deny benefits. If my insurance company denies payment for service(s) rendered by Saline Heart Group, I AGREE TO BE RESPONSIBLE FOR THE PAYMENT OF THE SERVICES RENDERED. I understand that I am responsible for any amount not covered by my insurance such as but not limited to deductible and co-insurance. I further understand that Saline Heart Group cannot accept responsibility for collection of my claim(s) or for negotiating a settlement on a disputed claim once your claim goes to a collection company for non-payment.

The undersigned acknowledges that all information provided is true and accurate.

Patient Signature: _____ Date: _____

Saline Heart Group, P.A.

Account # _____

Notice of Privacy Practices Receipt

Print Name of Patient: _____ Birth Date: _____

If you would like to give us permission to discuss your personal health information with family members or friends, please list them below.

1. _____

2. _____

3. _____

For Personal Representative of the Patient

(This area only applies to you if someone has power of attorney over you)

Print name of personal representative: _____

Signature of personal representative: _____

I acknowledge that I was provided with the Notice of Privacy Practices provided by Saline Heart Group.

Patient Signature: _____ Date: _____

Saline Heart Group, P.A.

Account # _____

Payment Policy

Please read the following carefully.

1. Payments can be made in the form of cash, check, or credit card.

2. You will be expected to pay your insurance co-pay every time you see a provider. Co-pays cannot be billed. You will be expected to pay your coinsurance and any unmet deductible.

3. All charges will be filed to your insurance unless otherwise requested.

4. Once your insurance has processed, you will receive a statement from Saline Heart Group by mail.

5. You will be responsible for all non-covered charges not payable by your insurance company.

6. All charges are expected to be paid in full unless prior arrangements have been made.

7. Uninsured patients are required to pay a $300.00 deposit at the time of visit. Payment arrangements can be made on the remaining balance.

I fully understand the payment policy as stated and agree to comply.

Patient Signature: _____ Date: _____

Signature of Authorized Agent: _____ Date: _____

Saline Heart Group, P.A.

Patient Questionnaire

Account # _____
Date _____

Patient Information:

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

Date of Birth: _____ Age: _____ Occupation: _____

Primary Care Physician: _____ Pharmacy Name: _____

Pharmacy Address: _____ Pharmacy Phone: _____

Allergies:

Are you allergic to iodine, seafood, or radiographic contrast dye? Yes ☐ No ☐

Please list ANY other allergies and describe the reaction:

Allergy to:	**Reaction:**
_____	_____
_____	_____

Current Medications:

***Remember to bring all medications with you at time of appointment**

Please list all medications (prescription and non-prescription) that you are currently taking:

Medication Name	**Dosage**	**How Often Taken?**	**Who Prescribed?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History:

Please check if you have had any of the following problems in the past:

_____ Cardiac arrest
_____ Heart valve disease
_____ Infection in the heart
_____ Abnormal EKG
_____ Palpitations, skips, or irregular heartbeat
_____ Pain in the arms, throat, jaw, or upper back
_____ High blood pressure
_____ Chest pain, pressure, or tightness

_____ Abnormal heart rhythms
_____ Blackouts or fainting spells
_____ Frequent dizzy spells
_____ Diabetes
_____ Kidney disease
_____ COPD
_____ Sleep apnea or other problems sleeping
_____ CPAP

	Date	**Location**	**Physician**
_____ Heart attack	_____	_____	_____
_____ Congestive heart failure	_____	_____	_____
_____ Stroke	_____	_____	_____
_____ Blood clots in veins or legs	_____	_____	_____
_____ Blood clots in lungs	_____	_____	_____

Past Cardiac Procedures or Tests:	**Date**	**Location**	**Physician**
Heart catheterization (dye test)	_____	_____	_____
Heart surgery (bypass, valve replacement)	_____	_____	_____
Vascular procedures (kidney or leg stents)	_____	_____	_____
Heart stent placement	_____	_____	_____
Electrophysiology study	_____	_____	_____
Pacemaker or AICD implant	_____	_____	_____
Echocardiogram	_____	_____	_____
Stress test (treadmill, etc.)	_____	_____	_____
Holter monitor	_____	_____	_____

Past Surgeries:

Please provide the year for all that apply:

_____ Gallbladder _____ Hernia _____ Appendix _____ Hysterectomy

_____ Tonsillectomy _____ Prostate _____ Breast biopsy or mastectomy

_____ Other: _____

Past Medical Illness:

Please list any serious illness for which you have been hospitalized (except admissions for surgery):

_____ _____

_____ _____

Social History and Lifestyle:

Do you drink alcohol? Yes ☐ No ☐ If Yes, how often? _____

Do you currently smoke? Yes ☐ No ☐ If Yes, how often? _____

How long have you been smoking? _____ If you quit smoking, when did you quit? _____

How many packs a day did you smoke? _____ How many years did you smoke before quitting? _____

Are you on a special diet? Yes ☐ No ☐ If Yes, what type of diet? _____

How many cups of caffeinated beverages do you drink on an average day? _____

Do you exercise on a regular basis? Yes ☐ No ☐ If Yes, what type of exercise and how often? _____

_____

Do you have a history of drug dependency? Yes ☐ No ☐ If Yes, specify: _____

Family History: Please list any parents, grandparents, siblings, or children who have had a heart attack, stroke, heart disease, stent placement, heart surgery, cardiac arrest, blackout spells, or vascular disease.

Relationship: _____ Condition: _____ At what age: ____ Deceased: Y N

Relationship: _____ Condition: _____ At what age: ____ Deceased: Y N

Relationship: _____ Condition: _____ At what age: ____ Deceased: Y N

Relationship: _____ Condition: _____ At what age: ____ Deceased: Y N

Thank you. Again, please be sure to bring all your medications to each visit with us.

Patient signature _____ **Date** _____

Physician signature _____ **Date** _____