LAS VEGAS CARDIOLOGY

PATIENT INFORMATION			
Last Name:		Social Security #:	
First Name:	Mid. Initial:	Date of Birth:	
Home Address1:		Age:	Sex:
Apt/Suite #:		Home Phone#:	
City, State, Zip:		Work Phone#:	
Email:		Cell Phone#:	

** You do not have to supply your email address, however, we are collecting information as Las Vegas Cardiology is working on ways to use the Internet to better communicate with our patients. We do not sell or provide our patients phone numbers, addresses or email addresses to any other organization. All information is held in the strictest confidence.

Race: African American ☐	Caucasian ☐	Asian ☐	Native American ☐	Pacific Islander ☐	Other ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐	Primary Language:

EMPLOYER INFORMATION	
Employer Name:	
Employer Address: ,	Emp. City/St/Zip:
Employer Suite #:	Employer Phone#:

EMGERGENCY CONTACT INFORMATION: In case of emergency who should be notified?	
Name:	Tel#

PRIMARY INSURANCE	
Plan/Policy Name:	Group #:
Plan Tel#:	Subscriber DOB:
Subscriber Name:	Subscriber ID/Policy #:

Relationship to Patient: ☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other

SECONDARY INSURANCE	
Plan/Policy Name:	Group #:
Plan Tel#:	Subscriber DOB:
Subscriber Name:	Subscriber ID/Policy #:

Relationship to Patient: ☐ Self ☐ Wife ☐ Husband ☐ Parent ☐ Other

For Office Use Only	
Pt#	Additional Notes:

ASSIGNMENT OF INSURANCE BENEFITS

The above information is complete and correct. I authorize treatment of the above patient. I hereby authorize the release of information necessary to file a claim with my insurance company and/or any other contracted payment source and I assign benefits otherwise payable to me to provider listed on claim. All services rendered are charged to the patient. The patient is responsible for all fees that may be added to my account in order to recover monies due to provider on claim.

Patient or authorized person's signature: _____ Date:

Patient Name:	
DOB:	Patient #:

CARDIOVASCULAR HISTORY

Please check "Yes" if you have a prior history and/or currently have any of the following:

- ☐ Y ☐ N REPORTED ECG WAS ABNORMAL
- ☐ Y ☐ N AORTIC ANEURYSM
- ☐ Y ☐ N HYPOTENSION
- ☐ Y ☐ N SINUS ARRHYTHMIA
- ☐ Y ☐ N ATRIAL FIBRILLATION AND FLUTTER
- ☐ Y ☐ N ATRIAL SEPTAL DEFECT
- ☐ Y ☐ N HYPERTENSION (SYSTEMIC)
- ☐ Y ☐ N HYPERLIPIDEMIA
- ☐ Y ☐ N FUNCTIONAL MURMUR
- ☐ Y ☐ N ATHEROSCLEROSIS OF OTHER CORONARY ARTERY BYPASS GRAFT
- ☐ Y ☐ N PACEMAKER PERMANENT PLACEMENT
- ☐ Y ☐ N IMPLANTABLE CARDIOVERTER-DEFIBRIL
- ☐ Y ☐ N CARDIOMYOPATHY
- ☐ Y ☐ N HEART VALVE REGURGITATION
- ☐ Y ☐ N MYOCARDIAL INFARCTION
- ☐ Y ☐ N VARICOSE VEINS
- ☐ Y ☐ N PERIPHERAL ARTERIAL DISEASE
- ☐ Y ☐ N PERICARDITIS
- ☐ Y ☐ N CONGENITAL HEART DISEASE
- ☐ Y ☐ N CONGESTIVE HEART FAILURE
- ☐ Y ☐ N PULMONARY EMBOLISM
- ☐ Y ☐ N CORONARY ARTERY DISEASE
- ☐ Y ☐ N PULMONARY HYPERTENSION
- ☐ Y ☐ N CATH STENT PLACEMENT
- ☐ Y ☐ N RHEUMATIC HEART FAILURE
- ☐ Y ☐ N VENOUS THROMBOSIS DEEP
- ☐ Y ☐ N STROKE SYNDROME
- ☐ Y ☐ N TRANSIENT ISCHEMIC ATTACK (TIA
- ☐ Y ☐ N DIABETES MELLITUS
- ☐ Y ☐ N HEART VALVE STENOSIS
- ☐ Y ☐ N HEART SURGERY
- ☐ Y ☐ N VENTRICULAR SEPTAL DEFECT

PAST CARDIAC TESTING

- ☐ Y CT Angiography Coronary Arteries With Quantitative Calcium
- ☐ Y ☐ N Continuous ECG Holter Monitor 24 Hour
- ☐ Y ☐ N Patient ECG Event Recording Hookup, Record, Disconnect
- ☐ Y ☐ N Echocardiogram
- ☐ Y ☐ N Cardiovascular Stress Test
- ☐ Y ☐ N Cardiac Catheterization (Diagnostic)

WHERE:

_____

_____

_____

WHEN:

_____

.

PAST CARDIOVASCULAR HISTORY (cont.):

MEDICATIONS:

List all medications that you are currently taking. (**NOT INCLUDING NON-PRESCRIPTIONS MEDICATIONS & HERBAL REMEDIES.)**

MEDICATION	DOSE (e.g. 50mg)	HOW OFTEN (e.g. 3x/day)	APPROXIMATE START DATE (MM/YYYY)	REASON FOR TAKING MEDICATION

(Note: If you need more room for your medication list ask staff for an additional form.)

TOBACCO USAGE:

Have you ever smoked or used any tobacco products?

☐ FORMER ☐PRESENT ☐NEVER (If you check NEVER skip this section)

How many packs/day? _____ How long? _____

ALLERGIES or SENSITIVITY to Medications:

	NO	YES
Are you allergic to any Medications?	☐	☐
Contrast Dyes	☐	☐
Iodine	☐	☐
Latex	☐	☐
Shellfish	☐	☐

If answered yes to any of the above, what is your reaction?

_____

_____

_____

Please list any known drug allergies:

_____

_____

_____

PHARMACY INFORMATION:

Fill your prescription every:

☐ 30 DAYS ☐ 90 DAYS ☐ NONE ☐ OTHER: _____

Do you fill your prescription through mail order? ☐ YES ☐ NO

(If yes, please fill out below.)

Pharmacy Name:

_____

Pharmacy Phone #:

_____

SIGNATURE (REQUIRED) _____ DATE: _____ (MM/DD/YYYY)

PATIENT INFORMATION			
Last Name:		Social Security #:	
First Name:	Mid. Initial:	Date of Birth:	
Home Address1:		Age:	Sex:
Apt/Suite #:		Home Phone#:	
City, State, Zip:		Work Phone#:	
Referring Physician:		Cell Phone#:	

This authorization expires 1 year (365 days) from the date signed below and covers only treatment for dates specified above.

I, the undersigned, have read the above and authorized the staff of the disclosing facility named to disclose such information as herein contained. I understand that this authorization may be withdrawn, by written request from me, at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law. The facility will not condition treatment, payment or enrollment upon the provision of an authorization including the consequences of refusal to sign the authorization. A photocopy of this authorization shall constitute a valid authorization.

Signature (REQUIRED) _____ **DATE:** _____ **(MM/DD/YYYY)**

(**OFFICE USE ONLY**)

REQUEST RECORDS FROM:

PHYSICIAN /FACILITY NAME:	FAX NUMBER:
ADDRESS:	PHONE NUMBER:
CITY/STATE/ZIP:	

PLEASE FORWARD RECORDS TO:

(PLEASE CHECK ONE OR BOTH)

MAIL TO:	**FAX TO:**
☐ Las Vegas Cardiology 7660 W. Cheyenne Ave. #112 Las Vegas, NV 89129	☐ Las Vegas Cardiology Fax Number: 702.489.9001

LAS VEGAS CARDIOLOGY

7660 W. Cheyenne Ave. #112, Las Vegas NV 89129
702.489.9000 OFFICE 702.489.9001 FAX

Federal law requires that we seek your acknowledgement of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of: _____ (mm/dd/yyyy) and that I understand that if I have any questions regarding this notice, I may contact the Privacy Officer.

I authorize the following person(s) access to the use or disclosure of my health information. I understand that this authorization is in effect until revoked in writing.

NAME:		RELATIONSHIP:	
NAME:		RELATIONSHIP:	
NAME:		RELATIONSHIP:	
NAME:		RELATIONSHIP:	

PATIENT:	DOB:
SIGNATURE (REQUIRED):	DATE:

SIGNATURE OF: ☐ PARENT ☐ LEGAL GUARDIAN	
SIGNATURE (REQUIRED):	DATE:
PRINT NAME:	

(FOR OFFICE USE ONLY)	
NOTICE OF PRIVACY PRACTICES SENT/DELIVERED ON:	INITIALS:
SIGNED ACKWOLEDGMENT OF RECEIPT RECEIVED ON:	INITIALS:
PATIENT REFUSED OR FAILED TO ACKNOWLEDGE RECEIPT ON:	INITIALS: