

Heart & Vascular Center of Arizona



ACCT. # _____

Most insurance carriers require us to submit claims for patient services. For this reason, we request all patients to fill out completely and sign the registration form on an annual basis. THANK YOU

PATIENT INFORMATION

Patient's Legal Name _____ Birth Date _____ S.S. # _____
Last First Middle

Address _____ Home Phone # (____) _____ Marital Status _____
Street City Zip Area Code

Patient's Employer's Name _____ Occupation _____

Employer's Address _____ Business Phone # (____) _____
Street City/St Zip Area Code

Patient's Primary Doctor _____ Drs. Phone # (____) _____
Name Street City/St Zip Area Code

Name of Emergency Contact _____ Phone # (____) _____ Relationship _____
Area Code

SPOUSE INFORMATION

Spouse Name _____ Birth Date _____ S.S. # _____
Last First Middle

Employer _____ Employer's Phone # _____

PRIMARY INSURANCE

Ins. Company Name _____ Address _____ Phone # _____

ID#/Policy # _____ Group # _____ Effective Date _____

Policy Holder's Name _____ Relationship to PT. _____

Policy Holder's SS# _____ Birthdate _____

Policy Holder's Address _____ Home Phone _____

Policy Holder's Employer _____ Business Phone _____

SECONDARY INSURANCE

Other Insurance Co. _____ Address _____ Phone _____

Other Insured (if other than patient) _____ Address _____ Phone _____

Birth Date _____ Relationship to Patient _____ ID #/Policy # _____ Group # _____

Other Insured's Employer _____ Address _____ Phone# _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary to process claims. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy procedures.



Responsible Party Signature

Date

PATIENT HISTORY FORM

LAST NAME: _____ FIRST NAME: _____ TODAY'S DATE: _____

NAME AND ADDRESS OF YOUR FAMILY OR REFERRING PHYSICIAN? _____

MAIN REASON FOR YOUR VISIT TODAY? _____

WHERE MAY WE CONTACT YOU WITH TEST RESULTS? _____

WITH WHOM MAY WE DISCUSS TEST RESULTS? _____

Review of Systems

Do you now or have you had any problems related to the following systems?

Circle Yes or No.

Constitutional Symptoms	(Comments)	Genitourinary	(Comments)
Weight change	Y N	Change in stream	Y N
Chills	Y N	Nocturia	Y N
Sleep Disorder	Y N	Urinary frequency	Y N
Other		Menstrual difficulties	Y N
		Other	
Eyes		Musculoskeletal	
Double Vision	Y N	Bone pain	Y N
Glaucoma	Y N	Muscle pain	Y N
Cataracts	Y N	Joint pain	Y N
Other		Other	
Ear / Nose / Throat / Mouth		Integumentary (Skin)	
Hearing changes	Y N	Rash	Y N
Sore throat	Y N	Lumps or bumps	Y N
Sinus problem	Y N	Moles, skin tags	Y N
Other		Other	
Cardiovascular		Neurological	
Chest pain/discomfort	Y N	Tremors	Y N
Irregular heartbeat	Y N	Dizzy spells	Y N
Swelling in ankles	Y N	Numbness/tingling	Y N
High Blood Pressure	Y N	Headaches	Y N
Leg pain while walking	Y N	Stroke	Y N
Pacemaker insertion	Y N	Problems with coordination	Y N
Other		Other	
Psychologic		Respiratory	
Are you generally happy?	Y N	Wheezing	Y N
Do you feel depressed?	Y N	Frequent cough	Y N
Do you feel anxious?	Y N	Shortness of breath	Y N
Other		Other	
Endocrine		Gastrointestinal	
Excessive thirst	Y N	Abdominal pain	Y N
Too hot/cold	Y N	Nausea/vomiting	Y N
Tired/sluggish	Y N	Indigestion/heartburn	Y N
Other		Other	
Hematologic / Lymphatic		Sexual History	
Swollen glands	Y N	Change in sex drive?	Y N
Blood clotting problem	Y N	Sexual performance satisfactory?	Y N
Bruising	Y N	Other	
Other			
Allergic / Immunologic		Last Exam	
Hay Fever	Y N	Date - Last Eye Exam: _____	
Drug allergies	Y N	Date - Last Dental Exam: _____	
Food	Y N	Women: Date of Last Pap Smear: _____	
		Women: Date of Last Mammogram: _____	
		Men: Date of Last Prostate Exam: _____	

Medical History

Medical (High Blood Pressure, Diabetes, Asthma, Cancer, Heart Disease, etc.)

Surgical (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)

Allergies to medications? Yes No (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

MEDICATIONS

Current prescription medicines

Name of drug	mg dose	# tablets	# times per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current prescription medicines

Name of drug	mg dose	# tablets	# times per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Immunizations

Date _____	Date _____
Tetanus (Adult) _____	TB Test _____
Influenza _____	Hepatitis A,B _____
Pneumonia _____	

OTC Medicines: (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins, herbals)

Women: Age of onset of Menses: _____ Age of Menopause: _____ Number of Pregnancies: _____ Number of Live Births: _____

Are you at risk for AIDS (blood transfusion, drug abuse, sexual orientation)? Yes No

Smoke? Yes No If yes, how much? _____ # of packs/day _____ # of years When did you stop smoking? _____

Chew Tobacco? Yes No If yes, how much and how long? _____

How much coffee or caffeinated beverages do you drink daily? _____

Alcohol? Yes No If yes, how much? _____

Exercise regularly? Yes No If yes, what and how frequently? _____

Have you experienced any falls? Yes No If yes, what and how frequently? _____

Routinely wear seatbelts? Yes No **Routinely wear a helmet?** Yes No

Family History

Father: Living - Age: _____ Deceased, Age at Death _____ (Cause) _____

Mother: Living - Age: _____ Deceased, Age at Death _____ (Cause) _____

Siblings: Number Living _____ Number deceased _____ (Cause) _____

List other illnesses in your family (Example - Diabetes, heart disease, colon cancer, breast cancer, prostate cancer, etc)

Family Member	Illness	Family Member	Illness
_____	_____	_____	_____
_____	_____	_____	_____

Social History

Where were you born and raised? _____ When did you move to Arizona? _____

Married Single Widowed Divorced Spouse's Name: _____ Age _____ Healthy? Y N

Kids? Names, Age, Sex: _____ M F _____ M F _____ M F

Who do you live with? _____ Do you have supportive family or friends in the area? Yes No

Do you have a Living Will or Healthcare Power of Attorney? Yes No

Do you require the assistance of another person to do your bathing, dressing, or walking around? _____

Education (High School, Some College, Degrees): _____ Occupation: _____

Religious preference? _____ Regularly attending: _____

Interests or hobbies? _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any change in my medical status. I also understand that if follow-up is needed, I will assume responsibility for such follow-up.

Patient Signature: _____

Physician: _____ M.D.

Date: _____

Date: _____

Heart & Vascular Center



of Arizona

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **Heart & Vascular Center of Arizona** may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Heart & Vascular Center of Arizona's** Notice of Privacy Practices for a more complete description of such uses and disclosures.

Heart & Vascular Center of Arizona reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Heart & Vascular Center of Arizona** Privacy Officer at 1331 N. 7th Street #375, Phoenix, AZ 85006.

With my consent, **Heart & Vascular Center of Arizona** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and insurance items; and in reference to my clinical care, including laboratory results, among others.

With my consent, **Heart & Vascular Center of Arizona** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked "Personal and Confidential."

With my consent, **Heart & Vascular Center of Arizona** may e-mail to my home or other designated location any items that assist the practice in carrying out our TPO, such as appointment reminders and patient statements. I have the right to request that, **Heart & Vascular Center of Arizona** restrict how it uses or discloses my PHI to carry out our TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Heart & Vascular Center of Arizona's** use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations and I have received a copy of the Notice of Privacy Practices prior to signing this consent.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Heart & Vascular Center of Arizona** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian

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