

HEART AND VASCULAR ASSOCIATES, LLC

BRYAN PIOTROWSKI, MD

B. NICOLE ROGERS, PA-C

130 Westmount Dr., Farmington MO 63640

PATIENT INFORMATION

Please complete and/or verify all information and make changes as necessary.

Today's Date:		Primary Care Physician Name:			
Patient Name (First-Middle-Last)		Date of Birth	Age	Gender M F	Marital Status M S D W
Home Phone No.	Cell Phone No.	Pt. Social Security No.	E-mail Address		
Address Street #		City/State/ZIP		Employment Status Employed Unemployed Retired Student	
Name of Employer/School	Occupation	Employer Address (Street-City-State-ZIP)		Employer Phone No.	
Emergency Contact	Relationship	Phone No.	Best # To Reach You During the Day Home Cell Other (Pls. specify)		

GUARANTOR INFORMATION / INSURANCE INFORMATION

Name of person who is financially responsible for this patient?		Relation to Patient	Phone No.	Date of Birth
Primary Insurance Co.	Subscriber Name	Date of Birth	Relationship to Patient	
Secondary Insurance Co.	Subscriber Name	Date of Birth	Relationship to Patient	

LEGAL GUARDIAN (IF MINOR)

Legal Guardian Name (First-Middle-Last)	Address Street #	City/State/ZIP	Phone No.
---	------------------	----------------	-----------

PATIENT DEMOGRAPHICS

Heart and Vascular Associates, LLC is participating in Meaningful Use. To better identify possible disparities in access and quality of healthcare based on race and ethnicity on a nation-wide level, we are required to ask the following demographic questions

<u>RACE</u>	<u>ETHNICITY</u>	<u>PREFERRED LANGUAGE</u>
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> English
<input type="checkbox"/> Asian	<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> Spanish
<input type="checkbox"/> African American	<input type="checkbox"/> I prefer not to report	<input type="checkbox"/> Sign Language
<input type="checkbox"/> Caucasian		<input type="checkbox"/> Other
<input type="checkbox"/> Other		<input type="checkbox"/> I prefer not to report
<input type="checkbox"/> I prefer not to report		

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I hereby assign payment of authorized Medicare, Medicaid and/or any Insurance Carrier listed to include major medical benefits to which I am entitled, to be made on my behalf to Heart and Vascular Associates, LLC for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, and/or any Insurance Carrier listed, any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Patient (Legal Guardian)'s Signature

Patient (Legal Guardian)'s Printed Name

Date

MEDICARE: Heart and Vascular Associates, LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

INSURANCE: I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that all office co-pays are due at time of service. In addition, I agree to pay any additional charges related to the cost of collection including but not limited to collection agency fees, reasonable attorney fees and court costs, in the event that I would fail to pay my bill.

Guarantor's Signature

Guarantor's Printed Name

Date

HEART AND VASCULAR ASSOCIATES, LLC

BRYAN PIOTROWSKI, MD

B. NICOLE ROGERS, PA-C

130 Westmount Dr., Farmington MO 63640

Patient Name: _____

Risk Assessment Coronary Risk Factors

	Yes	No
High Blood Pressure Medications:		
Diabetes Type:		
Smoker Packs per Day: Years Smoked:		

Possible Cardiac Symptoms (*occurring in the last 6 months*)

	Yes	No		Yes	No
Chest Pain (angina)			Leg/Ankle Swelling		
Shortness of Breath/ Wheezing			Blackouts/ Near Blackouts		
Chest Pressure/ Chest Tightness			Unusual Flutters (Palpitations)		

Family History

	Diabetes	Stroke	High Blood Pressure	Heart Attack
Mother				Before 55: Y/N
Father				Before 55: Y/N
Sister				Before 55: Y/N
Brother				Before 55: Y/N
Maternal Grandparent				Before 55: Y/N
Paternal Grandparent				Before 55: Y/N

Past Medical History

	Yes	No		Yes	No
Heart Disease/CAD			Thyroid		
Heart Attack			Insomnia		
Heart Cath/ Angiogram			Cancer		
Angioplasty/ Stent			Anxiety		
CABG			Inflammatory Disease		
Stroke/ TIA			High Cholesterol		
Blood Clots Medication/Filter:			Pacemaker/ Defibrillator Type:		
Lung Disease			Peripheral Vascular Disease		

HEART AND VASCULAR ASSOCIATES, LLC

BRYAN PIOTROWSKI, MD

B. NICOLE ROGERS, PA-C

130 Westmount Dr., Farmington MO 63640

Patient Name: _____

PAST SURGICAL HISTORY: *(List any other surgeries you have had and the year)*

CURRENT MEDICATIONS:

Name of Medication	Dosage (mg)	Frequency (times per day)

PHARMACY NAME: _____ PHONE NUMBER: _____

Yes No I authorize Heart and Vascular Associates to download my complete prescription history into my electronic health record.

Allergies: _____

NATURAL/HERBAL REMEDIES:

VITAMINS/SUPPLEMENTS:

OTHER/COMENTS:
