HEART AND VASCULAR ASSOCIATES, LLC

130 Westmount Drive, 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

RACE
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ African American
- ☐ Caucasian
- ☐ Other
- ☐ I prefer not to report

ETHNICITY
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ I prefer not to report

PREFERRED LANGUAGE
- ☐ English
- ☐ Spanish
- ☐ Sign Language
- ☐ Other
- ☐ 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**

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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
Father				Before 55: Y/N
Mother				Before 55: Y/N
Brother				Before 55: Y/N
Sister				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/ Defribilator Type:		
Lung Disease			Peripheral Vascular Disease		

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Patient Name: ________________________

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

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CURRENT MEDICATIONS: Please complete or provide a current medication list

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/Reactions:____

NATURAL/HERBAL REMEDIES:

____
____

VITAMINS/SUPPLEMENTS:

____
____
____

OTHER/COMENTS:

____
____
____