Patient Information

_____

Today's Date

_____ _____ _____ ____ _____

Name **DOB** **Age** **Sex** **Marital Status**

_____ _____

Address **Apt#**

City/State/Zip

_____

Home Phone **Cell Phone** **Work Phone**

_____

PREFERRED CONTACT PHONE #

_____

Email Address

_____

Employed By/Occupation

_____

Employers Address & Phone Number

_____

Spouse's Name

_____

Spouse's Employers Address & Phone Number

_____

Emergency Contact/Emergency Contact Phone#

_____

Referred By

_____

Primary Care Physician

COMPLETE CARDIOLOGY
Steven J. Eisenberg, MD

Please Complete All Pages

Office Visit Questionnaire

Name: Birth Date: / / Age: Today's Date: / /

Referred By: Primary Care Physician:

Reason for Visit:

Preferred Contact #: Email:

Pharmacy Name/Location/Phone Number:

Past Cardiovascular History

Have you ever had any of the following?

Heart attack	No / Yes	Stroke	No / Yes
Angina	No / Yes	TIA (mini-stroke)	No / Yes
Congestive heart failure	No / Yes	Loss of Consciousness	No / Yes
Enlarged Heart	No / Yes	Severe dizziness	No / Yes
Abnormal EKG	No / Yes	Irregular heart beat	No / Yes
Murmur	No / Yes	Rheumatic Fever	No / Yes
Lung Clot	No / Yes	Blood Clot in leg(s)	No / Yes
Pain in legs when walking	No / Yes	Other heart-related issues	No / Yes

Procedure History

Please Update Changes Since Last Annual Exam

	Date	*Results*
Stress Test		
Heart Cath		
Angioplasty		
Bypass Surgery		
Leg Artery Surgery		
Carotid Surgery		

Risk Factors

Do you have the following?

Diabetes Type 1	No / Yes	How long?
Diabetes Type 2	No / Yes	How long?
High Blood Pressure	No / Yes	How long?
High Cholesterol	No / Yes	How long?

Present values, if known: Cholesterol

HDL LDL Triglycerides

Medication Overview

Please Update Changes Since Last Annual Exam

List medications you are currently taking including non-prescription / herbal:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Any Previous Surgeries? If so, please list:

Are you allergic to latex? No / Yes

Are you allergic to shellfish/iodine? No / Yes

Do you have any drug allergies? If so, please list:

Social History

Use of Alcohol:	Never	Rarely	Moderate	Daily:
Use of Tobacco:	Never	Previously but quit		Daily:
Use of Drugs:	Never	Type/Frequency:		
Use of Caffeine:	Never	Frequency:		

Exercise: Type/Frequency:

# of Children:

(Please Update Changes Since Last Annual Exam)

Systems Review

Have you ever had or currently have any of the following?

General:					
Weight Loss	No / Yes	Weight Gain	No / Yes	Chills	No / Yes
Fever	No / Yes	Night Sweats	No / Yes		
Eyes:					
Glaucoma	No / Yes	Double Vision	No / Yes	Pain	No / Yes
Glasses/Contacts	No / Yes	Redness	No / Yes	Loss in Vision	No / Yes
ENT:					
Hearing loss	No / Yes	Ringing in Ears	No / Yes	Infections	No / Yes
Pain	No / Yes	Redness	No / Yes	Nosebleeds	No / Yes
Hoarseness	No / Yes	False Teeth	No / Yes	Seasonal allergies	No / Yes
Pulmonary/Respiratory:					
Cough	No / Yes	Phlegm	No / Yes	Coughing up blood	No / Yes
Wheezing	No / Yes	Asthma	No / Yes	Tuberculosis	No / Yes
Pneumonia	No / Yes	Emphysema	No / Yes	Snoring	No / Yes
Sleep Apnea	No / Yes				
Gastrointestinal					
Heartburn	No / Yes	Indigestion	No / Yes	Ulcers	No / Yes
Constipation	No / Yes	Diarrhea	No / Yes	Blood in Stool	No / Yes
Black Stool	No / Yes	Gallbladder disease	No / Yes	Hepatitis	No / Yes
Abdominal Pain	No / Yes	Polyps	No / Yes		
Psychiatric:					
Anxiety	No / Yes	Depression	No / Yes	Panic disorders	No / Yes
Suicidal thoughts	No / Yes	Drugs/alcohol abuse	No / Yes		
Musculoskeletal:					
Arthritis	No / Yes	Back/Neck/Hip pain	No / Yes	Bursitis	No / Yes
Sciatica	No / Yes	Joint Swelling	No / Yes		
Neurologic:					
Strokes	No / Yes	Migraines	No / Yes	Frequent headaches	No / Yes
Seizures	No / Yes	Memory Loss	No / Yes	Numbness/Tingling	No / Yes
Genitourinary:					
Stones	No / Yes	Kidney disease	No / Yes	Blood in urine	No / Yes
Herpes	No / Yes	HIV/AIDS	No / Yes		

Other:

Family Medical History **(Please Update Changes Since Last Annual Exam)**

☐ ***Check here if there are no changes since your last visit.***

	Age	Diseases	If Deceased, Cause of Death
Father:			
Mother:			
Brother:			
Sister:			

COMPLETE CARDIOLOGY, P.C.

PRACTICE FINANCIAL POLICY

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- Co-payments for office services are required at the time you register.
- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- For services that are covered by insurance, the practice requires payment of approximately 20% of the total estimated charges or the co-payment specified by your insurance.
- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been worked out.
- Returned checks are subject to a handling fee of $20.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We will allow you 90 days to pay any balance remaining after insurance payment. After that time, your account will accrue interest at the rate of Prime plus 2%. Our staff will make arrangements for you to make monthly payments over an approved term. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read and understand this policy.

Signature:_____ Date:_____

(Patient and/or Responsible Party)

To all of our patients at Complete Cardiology

Complete Cardiology is dedicated to ensuring your privacy. Please answer each privacy question and inform the Front Desk staff of any changes that may apply to you:

I authorize you to leave messages on my home answering machine regarding appointments and to inform me of laboratory/test results

Yes_____ No_____

I authorize you to contact or leave messages at my place of work

Yes_____ No_____

I authorize you to discuss my medical information with my family. Please provide family Members' names _____

Yes_____ No_____

I authorize you to view my external prescription history and I understand that prescription history from other medical providers and insurance companies may be included.

Yes_____ No_____

Signature_____ Date_____

Thank you for your cooperation

COMPLETE CARDIOLOGY, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print Patient's name) _____, acknowledge and agree that I have received a copy of Complete Cardiology, P.C's Notice of Privacy Practices.

_____	_____
Patient Signature	Date
_____	_____
Patient Legal Representative (if applicable)	Date
_____	_____
Print Name of Legal Representative	Relationship to Patient

FOR PRACTICE USE ONLY:

Complete Cardiology, P.C's made the following good faith efforts to obtain the above-referenced Patient's written acknowledgement of receipt of the Notice of Privacy Practices: