St. Louis Cardiology Center, PC Patient Information Form **PLEASE COMPLETE ALL FIELDS**

Today's Date: _____/_____/_____

Patient Legal Name:_____ Maiden Name:_____
Street Address:_____ Home Phone #:_____
City:_____ State:_____ Zip:_____ Cell #:_____
E-Mail Address:_____
Birthdate: _____/_____/_____ S.S#:_____
Marital Status: **S M W D P** Sex: **Male Female** Race:_____
Ethnicity: Not Hispanic/Latino Hispanic/Latino _____ Prefer Not to Answer
Employer:_____ Occupation:_____
Emergency Contact & Relationship:_____ Phone #:_____

Who is the Insurance Policy Holder? **Patient Spouse Parent Work Comp**
Policy Holder Name:_____ Relationship:_____
Street Address:_____
City:_____ State:_____ Zip:_____
Birthdate: _____/_____/_____ S.S.#:_____
Employer:_____ Occupation:_____
Employer Address:_____ Phone #:_____
Marital Status: **M S W D** Sex: **Male Female**

Primary Care or Referring Physician:_____ Phone #:_____
Pharmacy Name & Location:_____ Phone # :_____

Primary Insurer:_____ Work Comp Only, Date of Injury:_____
Group #:_____ Policy #:_____
Name on Policy:_____ Through Employer? **YES NO**

Secondary Insurer:_____
Group #:_____ Policy #:_____
Name on Policy:_____ Through Employer? **YES NO**

****In order to bill your insurance company, we need your signature below****

Unless you are a member of an insurance company that is contracted with St. Louis Cardiology Center, PC (SLCC) payment for services are expected on the day of the visit. Payment may be made by check, cash, money order or we accept most major credit cards. I authorize SLCC to also release any information acquired in the course of my examination or treatment to my insurance company in order to file a claim. I also understand that there may be a balance due from me after my insurance pays their portion. I also authorize payment directly to and assign to SLCC any medical benefits. A photostatic copy of this release shall be as valid as the original. I understand that if my account is not paid when due I will be responsible for all costs incurred in the collection process of my account. I further understand that my account will be reported to a credit bureau. SLCC does not deny benefits or services based on race , color, national origin, age, sex, religious or political beliefs. If you feel you have been descriminated against, you may file a Complaint of Deiscrimination with the Administrator of this facility. You will not suffer any penalty because you file a complaint.

Signature of Patient/Responsible Party:_____ Date:_____/_____/_____

PATIENT'S NAME:_____

MY MEDICINES

Name and Strength of Medicine*	Used For	How much do I Take	When do I Take This**	Notes
Prescription Medicines				
Nonprescription Medicines and Dietary Supplements (Vitamins, Minerals, Herbs and Other Substances)				

* Strength Means the # of mg or other units. You can find this on the label.

** How many times per day or week

PLEASE LIST ANY ALLERGIES YOU HAVE:_____

PREFERRED PHARMACY (NAME, PHONE # & ZIP CODE):_____

PATIENT HISTORY FORM

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT

Your Name: Date of Birth:

Date you are filling out this form:

Who is your physician or provider sending you to us? Dr._____

What type of complaint or disease is the reason for requesting this visit?

TELL US ABOUT YOURSELF:
Home situation (circle, or add in writing):

Single_____ Married (how long_____) Divorced (how long_____) Widowed (how long_____)

Domestic partnership_____

Employment:
Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Occupation: Type of work/jobs:_____

Habits: Do you smoke? No_____ Yes_____ If yes, how many packs per day?_____
If you have quit, how long ago?_____
Do you use alcohol? No_____ Yes_____ If yes, how often do you drink?_____
If you have quit, how long ago?_____
Do family or friends worry about your alcohol intake? _____

Have you ever had problems with drug use?_____

PAST MEDICAL HISTORY:
Please list other diseases from which you currently suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the past:

Please list any surgeries (operations), reason for the surgery, and date of surgery:

SYMPTOM REVIEW

Gastrointestinal

- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular

- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs

- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/Joint/Bone

- ☐ swelling of ankles or legs
- ☐ pain, weakness or numbness in
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

General

- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, Ears, Nose, Throat

- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary

- ☐ frequent or painful urination
- ☐ blood in urine

Skin

- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine

- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Neurologic

- ☐ history of stroke
- ☐ blackouts or loss of consciousness

FAMILY HISTORY:
Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	Grandparent Mat or Pat	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT

St. Louis Cardiology Center, PC

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Informed Consent to Evaluate and Treat

AUTHORIZATION TO GIVE MEDICAL CARE-CONSENT TO TREAT: I hereby voluntarily consent to outpatient care from St. Louis Cardiology, PC encompassing routine diagnostic procedures, examination and medical treatment including (but not limited to) routine lab work and administration of medication as prescribed by the provider. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by St. Louis Cardiology, PC as is necessary in the provider's judgment. I understand that during the course of treatment, healthcare workers may be exposed to the patients' blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the healthcare worker. I understand this consent will be valid and remain in effect as long as I attend this clinic.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize St. Louis Cardiology, PC to release any information acquired in the course of my examination and treatment to any authorized agent for the purpose of healthcare, treatment and payment. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies and community resources that assist me with my healthcare needs.

NOTIFICATION OF PRIVACY: I have received St. Louis Cardiology, PC Notice of Privacy Practices and Patient Rights.

NOTIFICATION TO ACCESS PRESCRIPTION AND MEDICAL HISTORY INFORMATION: I hereby authorize St. Louis Cardiology, PC to access historical prescription drug information.

ACKNOWLEDGEMENT OF PERSONAL PROPERTY: I understand that St. Louis Cardiology, PC shall not be liable for loss or damages of any personal property.

HEALTH INFORMATION EXCHANGES: St. Louis Cardiology, PC supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and healthcare providers that participate in the HIE network. Using HIE helps your healthcare providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who participate in the program and who are treating you, to have immediate access to your medical data that may be critical for your care. Making your health information available to your healthcare providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation, or cancel an opt-out choice, at any time by completing the appropriate form which will be provided upon your request.

FINANCIAL POLICIES: I authorize St. Louis Cardiology, PC to file a claim with my insurance carrier for services rendered. I authorize payment of medical benefits by any insurance carrier to either the clinic or myself. I understand that insurance is a contract between myself and my insurance carrier. St. Louis Cardiology, PC is not a party of this contract. We bill your insurance carrier as a courtesy to you. In order to properly bill your insurance carrier, we require that you disclose all insurance information including primary and secondary insurance cards, as well as any change of insurance information within 30 days of service. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. It is your responsibility to determine if your insurance company is contracted with us. If your insurance company is not contracted with us, you are responsible to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately, all copayments, deductibles and coinsurances apply. I understand that if my insurance requires a referral from my primary care physician it is my responsibility to obtain that referral. All copayments are the patient's responsibility at the time services are rendered. If you are uninsured, please note that your account is your responsibility. No patient will be denied emergency treatment due to his/her ability to pay. Discounts for essential services are offered dependent on income and household size as compared to the current federal poverty guidelines. Please inquire for more details. Regardless of any personal arrangements that a patient might have outside of our office, if you are 18 years of age or older and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party. I understand that hospital services (i.e. Laboratory tests, diagnostic images such as MRI, CT, US and Cardiac Studies) are billed separately by those vendors and therefore not included in our charges. Clinic discounts do not apply to hospital bills. The patient will need to contact the Hospital regarding charges and payments. Since we are an independent practice, any financial assistance you may receive from the hospital is not honored by this office unless approved by the physician

NO SHOW APPOINTMENTS: I understand that if I do not show up for a scheduled appointment, office or testing, without a minimum of a 24-hour notice. I also understand that if I am more than 15 minutes late for my appointment that I will need to reschedule and that a missed appointment charge will apply. I understand that will be billed a $20 missed appointment charge for an office visit and a $50 charge for a missed testing appointment.

I understand that I may revoke this consent in writing; extent that the organization has already taken action in reliance thereof. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me. ***My signature below indicates that I understand and accept the consent form.***

Patient Signature:_____ Date:_____

OR

Responsible Party Signature:_____ Date:_____

Relationship to Patient:_____

Witness:_____ Date:_____