South Mountain Cardiology

MEDICAL HISTORY

DATE______________ NAME__________________________________ D.O. B________________

REFERRRING PHYSICIAN____________________________PRIMARY CARE____

REASON FOR VISIT____

PHONE 1. _______________________2. _______________________ EMAIL: _____________________________________

PHARMACY NAME AND PHONE____

Would you like to sign up for the patient portal to have access to your medical record? Yes______ No_________

Would you like to receive appointment reminders via email or text? Yes_________ No_______________

PRESCRIPTION MEDICATIONS

MEDICINE DOSE (MG) TIMES A DAY

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

ALLERGIES To Medicines/ Iodine or I/V Contrast: Y N

If YES, please list

PAST MEDICAL HISTORY

Please indicate if you have had any of the following medical conditions:

Heart Attack Y N Hosp/Year

Cardiac Stent Y N Hosp/Year

Heart Bypass Surgery Y N Hosp/Year

Congestive Heart Failure Y N

Heart Valve Disease Y N

Pacemaker/Defibrillator Y N

Heart Rhythm Abnormality Y N

Peripheral Vasc Disease Y N

High Blood Pressure Y N

Diabetes Y N

Stroke or TIA Y N

High Cholesterol Y N

Thyroid Disorder Y N

Lung Disease Y N

Kidney Disease Y N

Liver Disease Y N

Stomach Ulcer Y N

Cancer Y N

Sleep Apnea Y N Wearing CPAP?

OTHER MEDICAL PROBLEMS

PAST SURGICAL HISTORY

Heart Surgery Y N When/Where

Vascular Surgery Y N When/Where

ANY other major SURGERIES Y N

HOSPITALIZATIONS DUE TO HEART CONDITION

SOCIAL HISTORY

Marital Status Occupation

Current Smoker Y N How Many/Day Number of years

Former Smoker Y N When Did You Quit

Alcohol Y N How Much/Day Hx of Heavy use

Drugs Y N What Kind? Hx of

Exercise Regularly Y N Type/Frequency

Medical Supplements Y N List:

FAMILY HISTORY

Parents, Brothers, OR Sisters with Heart Attacks, Stents, OR Bypass Surgery? Y N

If yes, Who and At What Age

Any Relative Who Died Suddenly from A Heart Attack?

REVIEW OF SYSTEMS

Please circle the symptom(s) you are experiencing

Circle this sentence If NONE of the below apply to you

Unexplained weight loss/ gain

Not able to exercise

Nose Bleeds

Bleeding gums/Dry mouth

Chest Pain/ chest pressure/ tightness

Jaw/arm pain with chest pain

Heart racing/pounding/skipping

Swelling of feet/ankles

Short of breath at rest

Shortness of breath with walking/activities

Shortness of breath when lying down

Cough

Snore

Sleep apnea/waking up gasping

Abdominal pain or tenderness

Frequent vomiting/vomit blood

Blood in stool/black stool

Pain in legs or buttocks with exercise

Heaviness/tiredness in legs

Back pain

Rash/Hives

Ulcers/skin changes in feet

Dizziness

Fainting spells

Seizures

Numbness/tingling

Depression/anxiety

Memory Loss

Excessive Fatigue

Excessive Hair loss

Easily bruise

Excessive bleeding

South Mountain Cardiology

PATIENT INFORMATION

Name: ____ D.O.B.____/_____/______

Address: ____

Male Female S.S.N: ______-_______-________ Phone no 1.: ________________________

Phone no 2.: ___________________________ Marital Status: ___________________________

Employer: _______________________________ Occupation: __________________________

Address: ____ Phone: _______________

Referring Physician: ________________________________ Phone: ____________________

Primary Care Physician: ______________________________ Phone: ____________________

Emergency Contact:_____________________Relationship:_______________ Phone:____________________

Who can receive information regarding your PHI: Name:_________________________Phone:_____________

AUTHORIZATION

- I hereby authorize SOUTH MOUNTAIN CARDIOLOGY to release any information acquired in the course of my examination or treatment.
- I hereby authorize any physician, hospital or medical care facility to provide all information on my medical history and treatment to SOUTH MOUNTAIN CARDIOLOGY.
- I hereby authorize photocopies of this form and my signature to be as valid as the original.

Signature: ____

Date: ______________________

REFERRALS

- If you are an HMO or managed care patient, you will need to obtain a referral from your primary care physician. It is the patient's responsibility to obtain the referral prior to their visit.

Signature: ____

Date: ____________________

PRIMARY INSURANCE INFORMATION

Name of Insurance: ____________________________________ Phone: __________________________

Claims Address: ____

Subscriber ID #: _____________________________ Group #: __________________________

Primary Subscriber Name: _________________________________

S.S.N: ________________D.O.B.: _______________________ Relation to Patient: _____________________________

SECONDARY INSURANCE INFORMATION

Name of Insurance: ______________________________ Phone: ______________

Claims Address: ____

Subscriber ID #: _________________________ Group #: ______________________

Primary Subscriber Name: ____________________________ S.S.N: _____________

D.O.B.: ____________________ Relation to Patient: __________________________

PATIENT WAIVER

If eligibility of insurance cannot be verified, or if deductible has not been met, I understand that I will be responsible for the cost of all medical services rendered. I hereby authorize payment directly to SOUTH MOUNTAIN CARDIOLOGY for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance.

Signature: ________________________________ Date: ____________________

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to SOUTH MOUNTAIN CARDIOLOGY for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

Signature: ________________________________ Date: ____________________

Notice and Acknowledgement

I acknowledge that I have received the South Mountain Cardiology Notice of Privacy Practice Policy.

____

Patient or Personal Representative Signature

____

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

Patient Testing Policy

The providers at South Mountain Cardiology schedule testing to be performed both in and outside our clinic. The results of the testing are discussed in person on a follow up visit. It is the patient's responsibility to follow up for this appointment. South Mountain Cardiology, it's providers or staff will not be responsible for any results should the patient not return for their follow up appointment. Thank you for your assistance in this matter.

I have read the above and will consider it my responsibility to return to the clinic in order to receive my results.

____

Print Name

____

Signature

____

Date

48 Hour Cancellation & "No Show", "No Confirm" Fee Policy

Each time a patient misses an appointment without providing adequate notification, another patient is prevented from receiving care. Therefore, South Mountain Cardiology reserves the right to charge a minimum fee of $ 25.00 for all missed/unconfirmed appointments that, in the absence of a compelling reason, are not canceled with 48-hour advance notice.

This fee will be billed to the patient, is ***not*** covered by ***any*** insurance, and must be paid before your next appointment. Several instances in any 12-month period may result in the termination of our practice. Thank you for your understanding and cooperation in our effort to better meet the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand the policy.

________________________________ __________________________
Patient Name Date

____
Signature

Due to ongoing COVID-19 pandemic, all patients are required to complete this form prior to being seen at ***South Mountain Cardiology***. Your visit is subject to approval upon completion of this form. Effective immediately anyone not being seen by a provider is restricted from being inside of the office at any time. These rules are being enforced to keep our patients and staff safe and healthy. We appreciate your cooperation and understanding.

Please answer each question below. CIRCLE ONE

1. Has the patient or anyone in your household traveled outside the US?

   YES NO

2. In the past two weeks has the patient or anyone in your household had contact with any person SUSPECTED to have contracted COVID-19?

   YES NO

3. In the past two weeks has the patient or anyone in your household had contact with any person CONFIRMED to have contracted COVID-19?

   YES NO

4. Do you have any of the following symptoms: Fever or chills, cough, shortness of breath, fatigue, muscle aches, body aches, headache, loss of taste or smell, sore throat, congestion, runny nose, nausea, vomiting, or diarrhea?

   YES NO