Account # ________________________ Date____/____/____ E1

PATIENT INFORMATION SHEET

Last___________________________________First________________________Middle Initial_____

Address____ E-mail address: ________________

City____State__________Zip_______________

Home Phone_______-__________-__________ Work Phone_______-__________-___________

Sex M or F Birth Date _____/_____/_____ Social Security Number _______-_______-__________
Circle

Employer (or retired from) ______________________________Employer Phone_______________

Date Retired ____________________

Family Doctor____
Name City

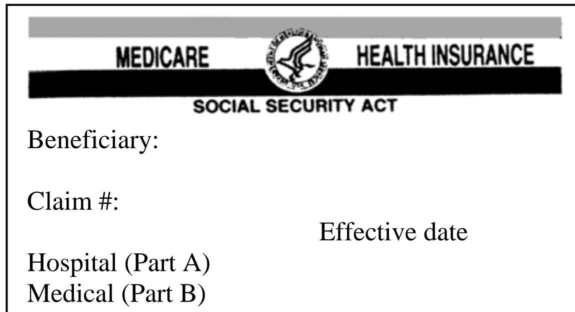
Cardiologist: ________________________ Cardiovascular Surgeon ________________________
Name Name

Marital Status: ☐ Married Spouse's name______________☐ Single ☐ Divorced ☐ Widow(er)

Name and phone number of contact person not living with you:

Name_____________________ Phone_____-______-__________ Relationship to you____________

INSURANCE INFORMATION: (Complete portion that applies to you)

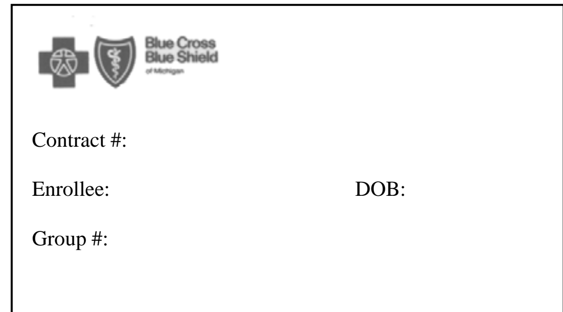


Beneficiary:

Claim #:

Effective date

Hospital (Part A)
Medical (Part B)



Contract #:

Enrollee: DOB:

Group #:

Is Medicare Primary? _______ If NO, please explain: ______________________________________

____

Other insurance: ____________________ Subscriber: _______________________ DOB___________

Address: ____ Phone: ___________________________

Group #: _______________________________ Policy #: ___________________________________

Medicaid Recipient I.D. Number: ____

YOUR INSURANCE CANNOT BE BILLED WITHOUT COMPLETE INFORMATION

AUTHORIZATION AND RELEASE OF INFORMATION

I hereby authorize the physicians of Michigan CardioVascular Institute to furnish and/or obtain information to and/or from myself, insurance carriers, hospitals and physicians concerning my illness, surgery and/or accident. I assign to the physicians all payments for medical services rendered. I understand that I will be financially responsible for all charges whether or not they are covered by my insurance.

Patient's Signature: _______________________________ Date: ____________

Michigan CardioVascular Institute
1015 S. Washington Ave.
Saginaw, MI 48601
Toll-free: 1-877-725-MCVI (6284)
Phone: (989) 754-3000
Fax: (989) 754-3002

Michigan CardioVascular Institute Financial Policy

1. Each Patient is responsible for his/her own bill.

2. As a courtesy, this office will submit claims to your insurance carrier. It is the responsibility of the patient to provide all insurance policy information or changes to this office.

3. It is the patient's responsibility to pursue slow payment or non-payment on the part of his/her insurance company by contacting the insurance company directly regarding the claim.

4. The patient agrees to monthly payments on all accounts. An account becomes delinquent after 30 days of no activity.

Authorization and Assignment

I, ______________________________________, authorize my insurance carrier or the Health Care Financing Administration to make payments on my behalf directly to Michigan Cardiovascular Institute. I understand that charges may exceed the payment paid by my insurance carrier and I will be responsible for the same. I understand I am fully responsible for all services including co-pay, deductibles, and rejected or unpaid.

I, hereby, authorize examination and any other medical services deemed necessary by my physician. I have been fully informed as to the nature of the treatment to be performed or administered by Michigan Cardiovascular Institute. I also authorize the release of any medical information necessary for my insurance company or the Health Care Financing Administration to process claims for services furnished by Michigan Cardiovascular Institute.

_______________________________________ __________ ________________
Patient's Signature (or parent of legal guardian) Date of Birth Date

____ ________________
Insurer's Signature (if other than patient) Date

03/2008

AUTHORIZATION FOR DISCLOSURE OF PATIENT INFORMATION *

I, ____, authorize Michigan CardioVascular Institute, P.C. (“MCVI”) to disclose the following protected health information about me

(please check one):

□ ALL information contained in MCVI’s files

□ Other ____

List recipient(s) name(s) ____

This authorization is given at my request unless a different purpose is listed below.

Describe specific purpose of disclosure(s), if other than at the patient’s request:______________________________

____

This authorization expires on:* □ date: ________________, 20___.
□ my death.
□ termination of my relationship with MCVI.

* If no box is checked, the Authorization will expire at the time the patient terminates his/her patient-provider relationship with MCVI.

I understand that, as described in MCVI’s Notice of Privacy Practices, I have the right to revoke this authorization in writing at any time by sending written notice to MCVI’s Privacy Officer at: 1015 S. Washington Ave., Saginaw, MI 48601.

I understand that a revocation is only effective to the extent MCVI has not already disclosed protected health information in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy my protected health information to be used or disclosed as permitted under federal or state law.

I understand that MCVI will not condition my treatment on my signature of this authorization. I also understand that I have the right to refuse to sign this authorization, but that any disclosures requested by me or by the intended recipient named above for which an authorization is required under applicable law will not be made by MCVI unless I sign this authorization.

____ ______________________, 20___

Signature of Patient or Personal Representative Date

Patient’s Date of Birth: __________________ Account # ______________________________

IF SIGNED BY PERSONAL REPRESENTATIVE, DOCUMENTATION OF THE PERSONAL REPRESENTATIVE’S AUTHORITY AND VERIFICATION OF THE PERSONAL REPRESENTATIVE’S IDENTITY MUST BE ATTACHED TO THIS FORM.

Medical History Form

E4

Name ____

Date of Birth ___________ **Primary Phys** _________________

HT: _________ **WT:** _________ **Today's Date** ________________

Cardiovascular History:

Heart Attack (MI)	Y/N	Defibrillator/ICD	Y/N
Coronary Artery Disease	Y/N	Chest Pain/Discomfort	Y/N
High Blood Pressure	Y/N	Angina	Y/N
Stroke/Mini-stroke	Y/N	Fainting/Black-outs	Y/N
Heart Murmur	Y/N	Lightheaded/Dizziness	Y/N
Heart Valve Problem	Y/N	Palpitations	Y/N
Rheumatic Fever	Y/N	Short of Breath	Y/N
Heart Failure	Y/N	Swelling in Feet/Hands	Y/N
Arrhythmia	Y/N	Blood Vessel Disease:	
Angioplasty/Stent	Y/N	In Legs	Y/N
Bypass Surgery	Y/N	In Neck	Y/N
Pacemaker	Y/N	In Kidneys	Y/N

Social History:

M/W/D/S

Children Y/N Minor/Adult

Live Alone Y/N

Live with Spouse Y/N

Live with Other _____________

Occupation _________________

Retired or Unemployed

Caffeine Amount _____________

Alcohol Amount ______________

Drug use ___________________

Regular Exercise Y/N

Diet Type___________________

Previous Cardiac Testing:	**Where:**	**When:**
Heart Cath	____________	____________
Angioplasty/Stent	____________	____________
Bypass Surgery	____________	____________
Stress Test	____________	____________
Echocardiogram	____________	____________
Holter/Event Monitor	____________	____________
Dopplers of Blood Vessels	____________	____________
Hospitalization for Heart	____________	____________

Coronary Risk Factors:

High Cholesterol Y/N

Diabetes Y/N

How long _______ Insulin Y/N

Overweight Y/N

High Blood Pressure Y/N

How long________________

Smoking History:

Previous Smoker Y/N

Current Smoker Y/N

Cigarettes Y/N

Pipe Y/N

Cigars Y/N

Other _______________

How many packs daily______

How many years___________

Previous/current second-hand smoke exposure Y/N

Family History: (circle if yes)

Heart disease/Heart failure/
High blood pressure/Diabetes
Stroke/ Kidney disease

Father-alive/deceased age_______

Cause of death________________

Mother-alive/deceased age_______

Cause of death________________

Brothers- alive/deceased________

Age/Cause of death________

Sisters- alive/deceased_________

Age/cause of death________

Recent Hospitalization:

____

____

____

History of Trauma/Accidents:

____

____

____

____

____

History of Unusual Illness:

____

____

____

Previous Surgery:	**Where:**	**When:**
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Medical History Form (cont'd):

Name ____________________

DOB ________________

Michigan CardioVascular Institute

REVIEW of SYSTEMS

General:

Fatigue	Y/N
Weakness	Y/N
Fever	Y/N
Chills	Y/N
Appetite Change	Y/N
Weight Change	Y/N
Abnormal Sweating	Y/N

Neurological:

Migraines	Y/N
Seizures	Y/N
Numbness	Y/N
Tremors	Y/N
Dizziness	Y/N
Lightheadedness	Y/N
Headaches	Y/N
Memory Problems	Y/N
Falls	Y/N

Other______________________

Psychiatric:

Diagnosis of:

Bi-Polar disorder	Y/N
Schizophrenia	Y/N
Obsessive/Compulsive	Y/N
Depression	Y/N
Anxiety	Y/N
Mood swings	Y/N
Panic Attacks	Y/N
Personality changes	Y/N

HEENT:

Glaucoma	Y/N
Cataracts	Y/N
Macular Degeneration	Y/N
Corrective lens use	Y/N
Blurred vision	Y/N
Visual field defect	Y/N
Hearing Problems	Y/N
Ringing in Ears	Y/N
Hearing Aids	Y/N
Sinus Problems	Y/N
Nosebleeds	Y/N
Voice changes	Y/N
Recurrent sore throat	Y/N

Other_______________

Cancer of: ____________________

____

Chemotherapy	Y/N
Radiation Therapy	Y/N
Port Placement	Y/N
Radiation Implants	Y/N

Pulmonary:

Chronic lung disease	Y/N
Asthma	Y/N
Emphysema	Y/N
Bronchitis	Y/N
Pneumonia	Y/N
TB	Y/N
Sleep Apnea	Y/N
Blood Clot in Lung	Y/N

Short of Breath:

With Activity only	Y/N
At Rest	Y/N
At Night	Y/N
Smoking History	Y/N
Wheezing	Y/N

Cough:

Non-productive/dry	Y/N
Productive	Y/N
Inhaled chemicals/dust	Y/N

Other______________________

Gastrointestinal:

Hiatal Hernia	Y/N
Reflux	Y/N
Ulcers/Gastritis	Y/N
Hernia	Y/N
Colitis/Crohn's	Y/N
Diverticulitis	Y/N
Gall Bladder disease	Y/N
Hepatitis	Y/N
Cirrhosis	Y/N
Pancreatitis	Y/N
Heartburn/indigestion	Y/N
Nausea	Y/N
Vomiting	Y/N
Trouble swallowing	Y/N
Chronic diarrhea	Y/N
Chronic constipation	Y/N
Blood in Stool	Y/N
Yellow Jaundice	Y/N

Other ____________________

Genitourinary:

Kidney Failure	Y/N
Kidney stones	Y/N
Kidney/bladder infection	Y/N
Dialysis	Y/N
Prostate Problems	Y/N
Disease of ovaries/uterus	Y/N
Breast disease	Y/N
Blood in Urine	Y/N
Pain when urinating	Y/N
Frequent urination	Y/N
Urination at night	Y/N

Endocrine:

Thyroid disease	Y/N
Diabetes	Y/N
"Borderline" Diabetes	Y/N
Insulin Use	Y/N
Heat intolerance	Y/N
Cold intolerance	Y/N
Increased thirst	Y/N
Increased hunger	Y/N

Heme/Lymph:

Anemia	Y/N
Bleeding problems	Y/N
Clotting problems	Y/N
Transfusions	Y/N
Leukemia/lymphoma	Y/N
Blood clot in leg/lung	Y/N
Easy bruising	Y/N
Lymph node swelling	Y/N
Lymph node pain	Y/N

Skin:

Psoariasis	Y/N
Rashes	Y/N
Itching	Y/N

Musculoskeletal:

Osteoarthritis	Y/N
Rheumatoid Arthritis	Y/N
Gout	Y/N
Fractures	Y/N
Joint pain	Y/N
Back Problems	Y/N
Muscle disease	Y/N
Extremity weakness	Y/N
Cane/Walker use	Y/N
Wheelchair use	Y/N

Other______________________

Current Medications:

____

____

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____

____

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____

____

____

ALLERGY to medications:

____

____

____

Reviewed by:____________________________

Nurse's signature

Reviewed by:__________________________MD