Saline Heart Group, PA

www.salineheartgroup.com

Allan B. Hatch, M.D.
Paul J. Baxley, M.D.
Van H. De Bruyn, M.D.

Stefani Ford, PA-C
Kristie Cronkhite, APN
Lori Wise, APN

Patient Account # _____
Date: _____

Patient Information

In order for us to provide you with the best possible care, please fill out these forms as completely and accurately as possible.

Last Name: _____ First Name: _____ Middle Initial ____
Mailing Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Cell Phone #: _____ Home Ph#: _____ Email: _____
☐ Physical address is the same as mailing address
Physical Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Soc. Sec. #: _____
Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Spouse's Name: _____ Phone #: _____
Spouse's Employer: _____ Work Phone #: _____

Education: ☐ High School ☐ Associate Degree ☐ College ☐ Post Graduate
Race: ☐ Caucasian/White ☐ Black American ☐ American Indian ☐ Asian
Ethnic Group: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Language: ☐ English ☐ Spanish ☐ Vietnamese

Employer Information

Occupation: _____
Employer: _____ Work Phone #: _____

In Case of Emergency

Name: _____ Relationship: _____
Phone #: _____ Work Phone #: _____

Name: _____ Relationship: _____
Phone #: _____ Work Phone #: _____

Primary Care Physician: _____ Phone #: _____

Patient Account # _____

Insurance Information

Please give your insurance card & ID to the receptionist

Primary Insurance Carrier: _____ Phone #: _____
Policy #: _____ Group #: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____ Subscribers Soc. Sec. #: _____
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance Carrier: _____ Phone #: _____
Policy #: _____ Group #: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____ Subscribers Soc. Sec. #: _____
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Payment Information

Person Responsible for Bill: _____
Relationship to the patient: _____
Address (if different): _____
City: _____ State: _____ Zip Code: _____

Insurance Authorization

I authorize the release of medical information necessary to process the insurance claim(s). I authorize and direct my insurance carrier or intermediaries to issue payment check(s) directly to Saline Heart Group who rendered services at the office.

I understand that my insurance company may require an authorization number, precertification, and/or referral. Without this documentation, I understand that my insurance company may deny benefits. If my insurance company denies payment for service(s) rendered by Saline Heart Group who rendered services at the office I AGREE TO BE RESPONSIBLE FOR THE PAYMENT OF THE SERVICES RENDERED. I understand that I am responsible for any amount not covered by my insurance such as but not limited to deductible and co-insurance. I further understand that Saline Heart Group cannot accept responsibility for collection of my claim(s) or for negotiating a settlement on a disputed claim once your claim goes to a collection company for non-payment.

The undersigned acknowledges that all information provided is true and accurate.

Patient Signature: _____ Date: _____

Saline Heart Group, PA

www.salineheartgroup.com

Account # _____

Center for Medical Weight Loss
Ornish Reversal Program

NOTICE OF PRIVACY PRACTICES RECEIPT

Print Name of Patient:_____ Birth Date:_____

If you would like to give us permission to discuss your personal health information with family members or friends please list them below.

1. _____

2. _____

3. _____

For Personal Representative of the Patient

(This area only applies to you if someone has power of attorney over you)

Print name of personal representative: _____

Signature of personal representative: _____

I acknowledge that I was provided with the Notice of Privacy Practices provided by Saline Heart Group and/or Center for Medical Weight Loss.

Signature of patient: _____ Date: _____

Saline Heart Group, PA

www.salineheartgroup.com

Center for Medical Weight Loss
Ornish Reversal Program

Account # _____

PAYMENT POLICY

Please read the following carefully. The payment policy is as follows. All charges are expected to be paid in full unless prior arrangements have been made.

1. Initial office visits: Your initial office visit charges will be filed at your request, but you will be expected to pay our coinsurance and any deductible not met.

2. Uninsured patients: You are required to pay an initial payment at the time of visit. Payments can come in the form of cash, check, or credit card. Please contact our billing office, either in person or by phone, for details on payment arrangement for the balance on your account for services rendered.

3. Co-pays: You will be expected to pay your insurance co-pay every time you see the doctor. This cannot be billed.

4. Re-visits: We will file your insurance for you on revisits, but you will also be expected to pay your coinsurance and any deductible not met.

5. Non-covered charges: You will be responsible for all non-covered charges (lab, procedures, etc) not payable by your insurance company.

6. Questions: Please ask to speak with the billing office representative if you have inquiries about billing.

I FULLY UNDERSTAND THE PAYMENT POLICY AS STATED AND AGREE TO COMPLY.

_____ _____
Patient Signature Date

_____ _____
Signature of Authorized Agent Date

Saline Heart Group, P.A.

Patient Questionnaire

Patient Account #:_____
Date:_____

Patient Information:

First Name:_____ Middle Initial:_____ Last Name:_____

Date of Birth:_____ Age:_____ Occupation:_____

Pharmacy Name:_____ Pharmacy Address:_____ Pharmacy Phone:_____

Please list all doctors you see:

Doctor's Name	Type of Doctor	Reason for Seeing

Briefly describe your reason for consulting a heart doctor today:

_____

_____

Current Allergies:

Do you have ALLERGIES to iodine, seafood, or radiographic contrast dye? Yes ☐ No ☐

Please list ANY other allergies and describe the reaction:

Allergy to:	Reaction:

If more space is needed, you can use the bottom of the last page of this form.

Current Medications:

***Remember to bring all medications with you at time of appointment**

Please list all medications (prescription and non-prescription) that you are now taking or occasionally take:

Medication Name	Dosage	How Often Taken?	Who Prescribed?

Past Medical History:

Please check if you have had any of the following problems in the past:

_____ Heart attack
_____ Congestive heart failure
_____ Heart valve disease
_____ Infection in the heart
_____ Abnormal EKG
_____ Palpitations, skips, or irregular heartbeat
_____ Pain in the arms, throat, jaw, or upper back
_____ Blackouts or fainting spells
_____ High blood pressure
_____ Frequent dizzy spells
_____ Blood clots in veins or legs
_____ Blood clots in lungs
_____ Abnormal heart rhythms
_____ Chest pain, pressure, or tightness
_____ Stroke(s)
_____ Diabetes
_____ COPD
_____ Sleep apnea or other problems sleeping

Past Cardiac Procedures or Tests:	**Date**	**Location**	**Physician**
Heart catheterization (dye test)			
Heart surgery (bypass, valve replacement)			
Vascular procedures			
Heart stent placement			
Electrophysiology study			
Pacemaker or AICD implantation			
Echocardiogram			
Stress test (treadmill, etc.)			
Holter monitor			

Past Medical Illness:

Please list any serious illness for which you have been hospitalized (except admissions for surgery):

_____

Past Surgeries:

Please provide the year for all that apply:

_____ Gallbladder _____ Hernia _____ Appendix
_____ Tonsillectomy _____ Hysterectomy _____ Prostate
_____ Breast biopsy or mastectomy _____ Other Operations: _____

Social History and Lifestyle:

Do you drink alcohol? Yes ☐ No ☐ If Yes, how many drinks on an average day? _____
Do you currently smoke? Yes ☐ No ☐ If Yes, how much do you smoke? _____
How long have you been smoking? _____ If you quit smoking, when did you quit? _____
How many packs a day did you smoke? _____ How many years did you smoke before quitting? _____
Are you on a special diet? Yes ☐ No ☐ If Yes, what type of diet? _____
How many cups of caffeinated beverages do you drink on an average day? _____
Do you exercise on a regular basis? Yes ☐ No ☐ If Yes, what type of exercise and how often? _____
_____
Do you have a history of drug dependency? Yes ☐ No ☐ If Yes, specify: _____

Family History: Please list any brothers, sisters, parents, or children who have had a heart attack, stroke, angioplasty, heart disease, cardiac arrest, blackout spells, or vascular disease.

Relationship: _____ Condition: _____ At what age: ____ Deceased: Y N
Relationship: _____ Condition: _____ At what age: ____ Deceased: Y N
Relationship: _____ Condition: _____ At what age: ____ Deceased: Y N

Review of Systems:

Instructions: Check YES or NO to all of the following questions. If you answer YES, please explain on the right side of the page.

General:

Decreased exercise tolerance?	YES ☐	NO ☐	
Fatigue?	YES ☐	NO ☐	
Weight change? Gain ☐ Loss ☐	YES ☐	NO ☐	
Change in appetite?	YES ☐	NO ☐	

Integumentary (Skin):

Changes in moles?	YES ☐	NO ☐	
Rash?	YES ☐	NO ☐	
Itching?	YES ☐	NO ☐	
Changes in hair?	YES ☐	NO ☐	
Changes in nails?	YES ☐	NO ☐	

Eyes:

Do you wear glasses/contact lenses?	YES ☐	NO ☐	
Do you have blurred vision?	YES ☐	NO ☐	
Do you experience double vision?	YES ☐	NO ☐	
Do you have a history of cataracts?	YES ☐	NO ☐	
Glaucoma?	YES ☐	NO ☐	

Ear, Nose, Mouth, and throat:

Do you have a hearing deficit?	YES ☐	NO ☐	
Do you wear dentures/braces?	YES ☐	NO ☐	
Chronic sinus problems?	YES ☐	NO ☐	
Do you have nose bleeds?	YES ☐	NO ☐	
Hoarseness/changes in voice?	YES ☐	NO ☐	

Respiratory:

Do you wheeze?	YES ☐	NO ☐	
Do you have a chronic cough?	YES ☐	NO ☐	
Have you coughed up blood?	YES ☐	NO ☐	
Do you experience shortness of breath?	YES ☐	NO ☐	
At rest? ☐ With activity? ☐			
Do you snore?	YES ☐	NO ☐	

Cardiovascular:

Chest pain, pressure, or tightness?	YES ☐	NO ☐	
At rest? ☐ With activity? ☐			
How often? _____			
Heart palpitations (racing)?	YES ☐	NO ☐	
Irregular heartbeats?	YES ☐	NO ☐	
Short of breath while lying flat?	YES ☐	NO ☐	
At rest? ☐ With activity? ☐			
How often? _____			
Waking up panicky, short of breath?	YES ☐	NO ☐	
Swelling of feet or ankles?	YES ☐	NO ☐	
Pain in legs with walking?	YES ☐	NO ☐	

Episodes of dizziness/lightheadedness? YES ☐ NO ☐ _____
How often? _____
Getting worse? YES ☐ NO ☐

Episodes of passing out/loss of consciousness? YES ☐ NO ☐ _____
How often? _____
Getting worse? YES ☐ NO ☐

Is your quality of life or activities affected by these symptoms? YES ☐ NO ☐ _____
If yes, which symptoms? _____

Are any palpitations or shortness of breath worse after a bad night of sleep? YES ☐ NO ☐ _____

Gastrointestinal System:

Frequent nausea? YES ☐ NO ☐ _____
Frequent vomiting? YES ☐ NO ☐ _____
Abdominal pain? YES ☐ NO ☐ _____
Black, tarry stool? YES ☐ NO ☐ _____
Bright red blood in stool? YES ☐ NO ☐ _____
History of stomach ulcers? YES ☐ NO ☐ _____
Frequent diarrhea? YES ☐ NO ☐ _____
History of gallbladder problems? YES ☐ NO ☐ _____
History of liver problems? YES ☐ NO ☐ _____

Genitourinary:

Do you have pain with urination? YES ☐ NO ☐ _____
Sense of urgency to urinate? YES ☐ NO ☐ _____
Awaken frequently to urinate? YES ☐ NO ☐ _____
History of bladder or kidney infection? YES ☐ NO ☐ _____
History of kidney stones? YES ☐ NO ☐ _____
Males: prostate problems? YES ☐ NO ☐ _____
Females: post menopausal? YES ☐ NO ☐ _____
Currently taking hormone replacement? YES ☐ NO ☐ _____

Musculoskeletal:

Chronic back pain? YES ☐ NO ☐ _____
Arthritis? YES ☐ NO ☐ _____
History of gout? YES ☐ NO ☐ _____
Joint pain or stiffness? YES ☐ NO ☐ _____
Muscle pain or cramps? YES ☐ NO ☐ _____
Muscle weakness? YES ☐ NO ☐ _____
History of blood clots in legs? YES ☐ NO ☐ _____
History of varicose veins? YES ☐ NO ☐ _____

Neurological:

Temporary blurred vision/loss of vision? YES ☐ NO ☐ _____
Temporary weakness and /or tingling involving an arm or leg? YES ☐ NO ☐ _____
Severe headaches? YES ☐ NO ☐ _____
Convulsions/seizures? YES ☐ NO ☐ _____

Psychiatric:

History of depression?	YES ☐	NO ☐	_____
Chronic anxiety?	YES ☐	NO ☐	_____
Stress at work or home?	YES ☐	NO ☐	_____
History of drug or alcohol abuse?	YES ☐	NO ☐	_____
Trouble sleeping?	YES ☐	NO ☐	_____
Thoughts of suicide?	YES ☐	NO ☐	_____

Endocrine:

Fatigue?	YES ☐	NO ☐	_____
High cholesterol?	YES ☐	NO ☐	_____
Diabetes?	YES ☐	NO ☐	_____
Thyroid problems?	YES ☐	NO ☐	_____

Hematologic/Immunologic:

Chronic low blood count/anemia?	YES ☐	NO ☐	_____
Bleeding problems?	YES ☐	NO ☐	_____
Seasonal allergies?	YES ☐	NO ☐	_____
Food allergies?	YES ☐	NO ☐	_____

Fall Precautions:

Do you have a history of falling? Yes ☐ No ☐

Do you fall frequently? Yes ☐ No ☐

Are you currently on any medications that make you dizzy, lightheaded, or cause you to fall? _____

Patient Choices:

Do you have a living will and/or durable power of attorney for your healthcare needs? Yes ☐ No ☐

If yes, please bring that document with you to your visit.

If no, would you like more information on the subject? Yes ☐ No ☐

Do you have difficulties learning? Yes ☐ No ☐

How do you learn best? By listening ☐ Visually ☐ By touch ☐

Are you visually or hearing impaired and require the services of an interpreter? Yes ☐ No ☐

Are you a non-English speaking person who requires an interpreter? Yes ☐ No ☐

If you answered yes to the above question, what language do you speak? _____

Thank you. Again, please be sure to bring all your medications to each visit with us.

Please sign _____

Date _____