WCAC

WEST COAST ARRHYTHMIA CENTER

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NEW PATIENT INFORMATION

Patient Name: _____

Street Address: _____

City, State and Zip Code: _____

Out of State Address: _____

City, State and Zip Code: _____

Patient Home Phone: _____

Social Security Number: _____ Date of Birth: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Spouse Name: _____ Social Security #: _____

Employer: _____ Work Phone: _____

Referring Physician: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____ Relationship: _____

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Who may we thank for referring you to us? _____

Name: _____Date : _____
Last First Middle

Date of Birth: ___/____/____ Current age: _____ Social Security #: _____

Have you experienced any of the following symptoms?

Yes	No	
___	___	Chest pain
___	___	Shortness of breath
___	___	Palpitations
___	___	Dizziness or lightheadedness
___	___	Passing out or nearly passing out
___	___	Painful legs when walking
___	___	Swelling in your feet or legs

Have you been diagnosed with or treated for the following?

Yes	No		Yes	No	
___	___	Coronary artery disease	___	___	Thyroid condition
___	___	Heart attack	___	___	Diabetes (Type I or II)
___	___	High blood pressure	___	___	Cancer (including skin)
___	___	High cholesterol	___	___	Liver disease
___	___	Aortic aneurysm or dissection	___	___	Kidney disease
___	___	Irregular heart beat	___	___	Ulcers/gastric reflux
___	___	Lung disease	___	___	Blood clots
___	___	Pulmonary embolism	___	___	Circulatory problems

Other: _____

What surgeries have you had in the past?

Surgery:	**Date:**
_____	_____
_____	_____
_____	_____

Please list your current medications <u>including</u> over the counter supplements.

Name	Dosage	Directions

Do you have allergies to medication, seafood, iodine or x-ray dye? Yes_____ No_____
If yes, what medication(s)? _____
_____

What was your reaction to this/these medications? _____
_____

Have you ever been a smoker? Yes _____ No _____ Current _____ Former _____ How many years? _____ Average packs per day? _____ Year quit? _____

Do you consume alcohol? Yes ___ No ___ How often do you drink? _____

Marital status: Married _____ Single _____ Divorced _____ Widow/Widower _____

Do you have any children? _____ How many? _____

Are you currently employed or retired? Employed _____ Retired _____ Other _____
Occupation: _____

Have any of your <u>immediate</u> family members had the following?

Heart disease	Y/N	If yes, who? _____
Heart attack	Y/N	If yes, who? _____
Stroke or TIA	Y/N	If yes, who? _____
High cholesterol	Y/N	If yes, who? _____
High blood pressure	Y/N	If yes, who? _____
Diabetes	Y/N	If yes, who? _____
Arrhythmias	Y/N	If yes, who? _____
Fainting	Y/N	If yes, who? _____
Pacemaker/AICD	Y/N	If yes, who? _____

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by Interventional Cardiac Consultants, P.L.C. deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/insurance benefits be made either to me, or on my behalf, for any services furnished by Interventional Cardiac Consultants, P.L.C. I authorize any holder of medical information about me to be released to CMS/Insurance Carriers and its agents. Any information needed to determine these benefits or benefits related to services may be released.

I hereby authorize Interventional Cardiac Consultants, P.L.C. to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for elated services. I hereby authorize (assign) my insurance carrier(s)/Medicare to make payment directly to Interventional Cardiac Consultants, P.L.C. for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the physician's office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature: _____ Date: _____

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with:

( ) Spouse: _____

( ) Children: _____

( ) Other: _____

In case of emergency, please list the family members or significant others, if any, whom we may inform about your medical condition.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

PRIVACY NOTICE

I have received a copy of Interventional Cardiac Consultants, P.L.C. office's privacy notice

Signature: _____ Date: _____

Patient Name (print): _____ Witness: _____