CARDIOVASCULAR INSTITUTE OF SCOTTSDALE
PATIENT DEMOGRAPHIC INFORMATION SHEET
(Please Print)

SS#: _____ - ____ - _____ PATIENT'S NAME:_____
Last Name, First Name Middle Initial

PERMANENT ADDRESS: _____APT # _____

CITY:_____ STATE_____ ZIP _____

LOCAL ADDRESS: _____APT # _____

CITY:_____ STATE_____ ZIP _____

DATE OF BIRTH: _____/_____/_____ SEX: (M / F) MARITAL STATUS (S /M /W /D)
Month day year

Phone #:(_____)_____- _____ Work Phone #:(_____)_____- _____
Other Phone #:(_____)_____-_____ Email:_____

Please completely fill out the following:

Race: □ American Indian OR Alaska Native
□ Asian
□ Native Hawaiian OR Other Pacific Islander
□ Black OR African American
□ Hispanic
□ White
□ Other Pacific Islander_____
□ Other Race: _____
□ Undetermined/Refused to Report

Ethnicity: □Hispanic/ Latino □Not Hispanic/Latino
□ Undetermined/Refused to Report

Language: □ English □ Russian
□ Indian (Includes Hindi) □ Spanish
□ OTHER:_____

PRIMARY CARE PHYSICIAN: _____ PCP Phone:(_____)_____- _____
Last Name First Name

Emergency Contact: _____ Phone:(_____)_____-_____
Last Name First Name

Relation to Patient: _____ Patient Employer: _____

Primary Insurance

Ins. Co. Name: _____

Policy ID#_____ Group #_____

Relation to Patient: _____

Insured's Name: _____

Insured's Date of Birth:_____ M / F

Insured's SS# _____

Secondary Insurance

Ins. Co. Name: _____

Policy ID# _____Group#_____

Relation to Patient: _____

Insured's Name: _____

Insured's Date of Birth: _____M / F

Insured's SS# _____

I gave a copy of my Primary Insurance Card (Y)/(N) _ I gave a copy of my Secondary Insurance Card(Y)/(N)

CARDIOVASCULAR INSTITUTE OF SCOTTSDALE
PATIENT DEMOGRAPHIC INFORMATION SHEET
(Please Print)

Who may receive information regarding your Protected Health Information? (Check all that apply)

Spouse_____ Name: _____Date of Birth: ____/____/_____

Children ____ Name: _____Date of Birth: ____/____/_____
Name: _____Date of Birth: ____/____/_____
Parent/Guardian____ Name: _____Date of Birth: ____/____/_____
Name: _____Date of Birth: ____/____/_____
Significant Other/Friend Name: _____Date of Birth: ____/____/_____

May we leave detailed messages regarding test results and appointments on your answering machine? ___(Y) ___(N)

Consent to Obtain Prescription History:
I give my consent to obtain any and all records pertaining to my prescription history: **INITIAL AND DATE**_____

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I acknowledge that Cardiovascular Institute of Scottsdale may forward my personal health information to any facilities where testing or procedures may be scheduled. I may revoke this at any time by giving written notification to this provider.

Date:_____ Signature_____
Circle One (PATIENT/ PARENT /GUARDIAN)

CARDIOVASCULAR INSTITUTE OF SCOTTSDALE

Our Financial Policy

Our office will provide the highest quality of care to our patients while being considerate of the cost... Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any services rendered:

- ♥ We will bill contracted insurance companies as a courtesy... Your current insurance information is required for accurate billing. You (patient or responsible party) will be responsible for all co-payments, co-insurance, deductible plus any balance due on non-covered services from your plan. **Co-payments are due at the time of service.**
- ♥ If you **do not** have insurance, payment is expected at the time of service unless other arrangements have been made.
- ♥ Our staff will be happy to assist you with any questions you have, but we cannot be responsible for knowing or interpreting the benefits of each individual policy. All patients are responsible for knowing the requirements of their insurance plans, including in-network lab and radiology facilities. Patients are also responsible for knowing what services are covered by their plan and which services need a pre-authorization.
- ♥ **Please be advised that your coverage for testing performed in the office may differ from office visit benefits.**

---

1. I have read the above statement and I understand that I am financially responsible for all co-payments, co-insurance, deductibles plus any balance due on non-covered services from my plan. I understand that all co-pays are due at the time of service.
2. I understand I am responsible for any services that my plan determines as “non-covered,” such as, but not limited to, preventative and/or routine services.
3. I understand that I will be billed a $25.00 service charge for all checks that are returned by the bank.
4. I understand that the office is not able to verify insurance benefits for every patient. I understand that I am responsible for understanding my plan’s benefits and for selecting a physician and/ or facility under my plan.
5. I agree to pay all the amounts owed and all expenses incurred in collecting any unpaid balance, including a 35% fee from the collection agency.
6. I understand that I may be charged a fee of $50.00 for any appointments cancelled without 24 hour advanced notice.
7. I understand there may be a charge of $75.00 if I request medical records sent to an insurance company, regarding disability, automotive or life, or records sent to an attorney or law firm. I also understand that a $50.00 fee will be applicable for completion of disability paperwork, FMLA or life insurance paperwork. I understand that each process may take up to 10 business days.
8. I understand that the office may request that I fill out demographic and insurance information every 6 months, even if there has been no change.
9. I authorize the release of medical information to my insurance company. I understand that if I do not authorize release, then payment will likely be denied or delayed by my insurance company. In this circumstance, I understand that I will be responsible for my bill.

By signing below, I acknowledge that I have read and understand the above policy.

Signature ________________________________ Date _______________________

Print Name ____

CardioVascular Institute of Scottsdale

Please fill out the Initial Patient Information Survey, and bring the following items.
[1]Completed Initial Patient Information Survey, [2] Insurance card.

First Name: _____

Last Name: _____ *DOB:* _____

Reason for Visit: _____

Referring physician: _____

*Pharmacy Name*_____

*Location:*_____

Please provide the medications you currently take with dosage and frequency

_____
_____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY

Please indicate any current/past medical conditions.

Circulatory System Conditions

- ☐ *Abdominal Aortic Aneurysm*
- ☐ *Atrial Fibrillation*
- ☐ *Dysrhythmia (rhythm abnormalities)*
- ☐ *Carotid Artery Disease*
- ☐ *Congestive Heart Failure*
- ☐ *Heart Transplant*
- ☐ *Hyperlipidemia (high cholesterol)*
- ☐ *Hypertension (high blood pressure)*
- ☐ *Mitral Valve Pro lapse*
- ☐ *Myocardial Infarction (heart attack)*
- ☐ *Coronary Artery Disease*
- ☐ *Peripheral Vascular Disease (PAD)*
- ☐ *Varicose Veins*

Endocrine & Metabolic Conditions

- ☐ *Diabetes Type I*
- ☐ *Diabetes Type II*
- ☐ *Hypothyroidism (underactive thyroid)*

Gastrointestinal Conditions

- ☐ *GERD (Reflux Disease)*
- ☐ *Hiatal Hernia*

Pulmonary Conditions

- ☐ *Asthma*
- ☐ *COPD / Emphysema*

Please list any other medical conditions you have not listed above.

_____
_____
_____
_____

CardioVascular Institute of Scottsdale

ALLERGIES

Do you have any allergies to medications? If yes, please indicate name/s and reaction.

☐ *No known medication allergies*

Medication	***Reaction***

PREVIOUS SURGERIES

Please provide a list of previous surgeries.

☐ *None.* _____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please fill out your family medical history below:

Family Member	***Alive***	***Current Age OR Age at Death***	***Cause of Death***	***Medical Conditions***
Mother	*YES / NO*			
Father	*YES / NO*			
Maternal Grandmother	*YES / NO*			
Maternal Grandfather	*YES / NO*			
Paternal Grandmother	*YES / NO*			
Paternal Grandfather	*YES / NO*			
Brothers	*YES / NO*			
Sisters	*YES / NO*			

_____

CardioVascular Institute of Scottsdale

SOCIAL HISTORY

Personal Relations

Occupation/Current job: _____

☐ *Unemployed* → *Last job:* _____

☐ *Retired* → *Last job:* _____

Marital Status: ☐ *Single* / ☐ *Married* / ☐ *Partnered* ☐ *Separated* / ☐ *Divorced* / ☐ *Widowed*

Tobacco Use

Do you now or have you ever been a cigarette/cigar smoker? ☐ *Yes*, ☐ *No*

Years smoked: _____, *Packs/Day:* _____

If you quit, when (Date)? _____

Frequency Cigar Smoking: _____

Frequency Chew Tobacco: _____

Alcohol Consumption

Do you consume alcohol? _____

If no, have you ever been a drinker: _____ *Sober since:* _____

Type: ☐ *Beer* ☐ *Hard Liquor* ☐ *Wine*

Frequency: _____

Caffeine Consumption

Type: ☐ *None* ☐ *Coffee* ☐ *Tea* ☐ *Soda* ☐ *daily chocolates* ☐ *energy drinks*

Frequency: _____

Recreational Drugs

Do you currently or have you used recreational drugs? ☐ *NO* / ☐ *YES*

*If YES, drugs Used/frequency:*_____

*Date quit:*_____

CardioVascular Institute of Scottsdale

REVIEW OF SYSTEMS: *Please indicate yes or no to the following symptoms.*

General/Constitutional	***No***	***Yes***
Change in Appetite		
Chills/Fever		
Fatigue/Weakness		
Night Sweats		
Weight Gain		
Weight Loss		
Eyes	***No***	***Yes***
Blurred Vision/Loss of Vision		
Dry Eye		
Itching and redness		
Red Eye		
Ears/Nose/Throat	***No***	***Yes***
Decreased Hearing		
Difficulty Swallowing		
Ear Pain		
Nosebleed		
Ringing in the Ears		
Digestive System	***No***	***Yes***
Abdominal pain		
Blood in Stool		
Constipation		
Diarrhea		
Difficulty Swallowing		
Heartburn		
Hematemesis		
Nausea/Vomiting		
Skin	***No***	***Yes***
Blistering of Skin		
Discoloration		
Eczema		
Itching		
Rash		
Sun Sensitivity		

Hematology	***No***	***Yes***
Easy Bruising		
Prolonged Bleeding		
Recent Blood Transfusion		
Swollen Glands		
Respiratory	***No***	***Yes***
Cough		
Spitting out blood		
Shortness of Breath at Rest		
Shortness of Breath with Exertion		
Sputum Production		
Wheezing		
Cardiovascular	***No***	***Yes***
Chest Pain at Rest		
Chest Pain with Exertion		
Difficulty Laying Flat		
Dizziness/Lightheadedness		
Fluid accumulation in the Legs		
Palpitations		
Musculoskeletal	***No***	***Yes***
Joint Stiffness		
Leg Cramps		
Muscle Aches		
Swollen Joints		
Peripheral Vascular	***No***	***Yes***
Blanching of Skin		
Cold Extremities		
Decreased Sensation in Extremities		
Painful Extremities		
Pain/Cramping in Legs After Exertion		
Ulceration of Feet		
Neurologic	***No***	***Yes***
Balance Difficulty		
Fainting		
Gait Abnormality		
Loss of Strength		
Memory Loss		
Seizures		
Tingling/Numbness		
Tremor		

Signature_____

Date _____

THE FOLLOWING INSURANCE COMPANIES REQUIRE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN ***PRIOR*** TO YOUR VISIT .

PHOENIX DIRECT

OPTUM

AETNA COMMERCIAL HMO AND MEDICARE HMO

HUMANA COMMERCIAL HMO AND MEDICARE HMO

CIGNA COMMERCIAL HMO

BLUE CROSS COMMERCIAL HMO

BLUE CROSS MEDICARE ADVANTAGE HMO

BRIDGEWAY MEDICARE ADVANTAGE

EVERCARE SELECT

HEALTHNET COMMERCIAL HMO

HEALTHNET AHCCCS

INDIAN HEALTH SERVICES

TRICARE PRIME

TRIWEST/VA

UHC NAVIGATE

UHC COMPASS PLUS

If you are unsure if you need a referral, please contact your insurance company as it is the patient's responsibility to secure a valid referral ***prior*** to visit.