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|---------------------------------|---------------------------|----------------------|
| Cardiovascular Associates, S.C. | Hoffman Estates – Site | Barrington - Site |
| 800 Biesterfield Road | 1555 Barrington Road | 450 W. Hwy 22, #230 |
| Wimmer Building, Ground Floor | Doc. Bldg. III Suite 4250 | Barrington, IL 60010 |
| Elk Grove Village, IL 6007 | Hoffman Estates, IL 60195 | |

Patient Name _____ Gender M _____ F _____

Address _____ City/State/Zip _____

Home Phone # () _____ Work Phone # () _____

Employer _____

Marital Status _____ Date of Birth _____ Age _____ Social Security # _____

Spouse's Name _____ Social Security # _____

How did you hear about our practice? _____

Referring Physician _____ Phone # () _____

Address _____

Family Physician _____ Phone # () _____

Address _____

INSURANCE INFORMATION

Primary

Insurance name _____

Insurance address _____ Phone # () _____

Subscriber name _____ Relationship _____

Gender M _____ F _____ Date of Birth _____ Social Security # _____

ID # _____ Group # _____

Secondary

Insurance name _____

Insurance address _____ Phone # () _____

Subscriber name _____ Relationship _____

Gender M _____ F _____ Date of Birth _____ Social Security # _____

ID # _____ Group # _____

In Case of Emergency, notify

Relationship _____ **Phone # ()** _____

I hereby authorize my insurance benefits to be paid directly to the above-signed physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers. Although my insurance company may cover my services, I am aware that I am personally responsible for all charges. A Photostat copy of this authorization will be as valid as the original.

Signature of patient _____ **Date** _____

**Cardiovascular Associates
Medical History**

Name: _____ Sex: **M** ___ **F** ___ Date: _____

Referred by: _____

Current Medical Problem: _____

Allergies: _____

Medications: _____

Past Medical History:

| | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer |

Other: _____

Past Surgical History (or Hospitalizations) _____

Social History:

Who do you live with? _____ what type of work? _____

Recreational Activities? _____

Smoke? N _____ Y (how much?) _____ (how long?) _____

Alcohol? N _____ Y (how much?) _____ Caffeine? N _____ Y (how much) _____

Family History:

High Blood Pressure? Father _____ Mother _____ Brother/Sister _____

Heart attack? Father _____ Mother _____ Brother/Sister _____

Diabetes? Father _____ Mother _____ Brother/Sister _____

Stroke? Father _____ Mother _____ Brother/Sister _____

Heart Disease? Father _____ Mother _____ Brother/Sister _____

Cancer? Father _____ Mother _____ Brother/Sister _____

Other Problems:

| | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Chest Discomfort | <input type="checkbox"/> Irregular Heart Beats | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Leg Pain |

Other: _____

If you have a specific request for method of releasing your medical information, please list:

Form Completed By: _____ Date: _____

(For physician Use Only) Reviewed by: _____ Date: _____

Reviewed by: _____ **Date:** _____

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by Cardiovascular Associates S.C. and its employees or designees I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. (____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (____)

ASSIGNMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTEE/ COLLECTION FEE.

I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorneys fees. (____)

PRIVACY POLICY. I acknowledge having received the Practice's, "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent. (____)

ROUTINE COMMUNICATION OF MEDICAL INFORMATION. I acknowledge that the present communication method(s) that my physician and his/her staff follow to confirm appointments, inform me of my test results and changes to my treatment plan are acceptable to me. I acknowledge that I can request a reasonable alternative method of communication by listing it below. (____)

Patient or Authorized Person Signature Relationship Date

Witness Signature **Date**

Patient unable to sign. Verbal consent given. Reason: _____