Asheville Cardiology Associates

5 Vanderbilt Park Drive
Asheville, NC 28803
(828) 274-6000 phone
(828) 274-6025 fax

Patient Information

Office Use Only

Date:_____ ACA#:_____ Referring Physician:_____

Address:_____ Phone:_____

PLEASE *PRINT*

Patient's Name:_____
First Middle Last

Street Address:_____
Street City State Zip County

Mailing Address:_____
Street City State Zip County

Residence Phone:_____ Birthdate:__/__/__ Age:_____ Sex:_____

Cellular Phone:_____ Email Address:_____

Marital Status:_____ Social Security #:___–___–_____ Retired: ❑ Yes ❑ No

If yes, retirement date:_____ If no, patient's employer:_____

Employer's Address:_____ Business Phone:_____

Spouse's Name:_____ Social Security #:___–___–_____

Spouse Retired: ❑ Yes ❑ No If yes, retirement date:_____

If no, spouse's employer:_____

Spouse's Employer Address:_____ Business Phone:_____

Whom may we contact (NOT LIVING WITH YOU) in case of an emergency or if we need to change an appointment and cannot reach you?

Name:_____ Relationship:_____

Address:_____ Phone:_____

Please Complete Backside of Sheet

Insurance Information: **Please show receptionist your insurance card/Medicare/Medicaid Card**

PLEASE *PRINT*:

Primary Insurance: _____

Claims Address: _____ ☐
Street City State Zip

Policy #: _____ Group #: _____ Employer: _____

Insured's Name: _____ Relationship to Insured: _____

Insured's Date of Birth: ___/___/___ Insured's Social Security #: ___ – ___ – ___

Secondary Insurance: _____

Claims Address: _____ ☐
Street City State Zip

Policy #: _____ Group #: _____ Employer: _____

Insured's Name: _____ Relationship to Insured: _____

Insured's Date of Birth: ___/___/___ Insured's Social Security #: ___ – ___ – ___

Do you receive reimbursement or assistance with medication purchases? ☐ Yes ☐ No

Have you ever seen one of our physician's before? _____ ☐ If yes, please provide date: _____

Assignment of Benefits

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare Beneficiary, be made on my behalf to Asheville Cardiology Associates for any services provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for services provided by the organization to the Center for Medicare & Medicaid Services, my insurance carrier or other entity being billed for these services.

I understand that I am financially responsible to Asheville Cardiology Associates for any co-pays, co-insurance, deductibles or charges not covered by my health care benefits. It is my responsibility to notify Asheville Cardiology Associates of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Asheville Cardiology Associates and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that failure to pay any outstanding balances within one-hundred twenty (120) days of service may result in my account being considered for further collection activity, including but not limited to, placement with an outside collection agency. If further collection action is taken, I may be held responsible for the cost of that collection, including attorney and court costs.

I understand that by signing this form I am accepting financial responsibility as explained above for all payments due Asheville Cardiology Associates.

Signed: _____ Date: _____

Consent for Treatment

I authorize Asheville Cardiology Associates' personnel to perform on me the care ordered by my physicians. I understand I have the right to be informed by my physicians of the nature and the purpose of any proposed operation or procedure and any available alternative methods of treatment, together with an explanation of the risks associated with each of them.

Signature: _____ Date: _____

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Patient Name: _____ Date: _____

Referring MD: _____ Family MD: _____

Date of Birth: _____ Age: _____ Sex: Male ☐ Female ☐

Height: _____ Weight: _____

Marital Status (circle one): ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Number of Children: _____

Occupation (circle one): ☐ Working ☐ Retired ☐ Student ☐ Homemaker ☐ Disabled

Personal Health History

What is the reason for this visit?

_____

_____

Do you currently smoke? Yes ☐ No ☐

If yes, number of packs per day: _____

Number of years: _____

Have you ever smoked in the past? Yes ☐ No ☐

Date stopped: _____

Do you drink alcoholic beverages? Yes ☐ No ☐

How many drinks per day: _____

Do you drink beverages containing caffeine? Yes ☐ No ☐

How many per day: _____

Do you exercise? Yes ☐ No ☐

If yes, what is your exercise routine?

_____

_____

Are you following a special diet? Yes ☐ No ☐

If yes, please describe:

_____

_____

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Past Medical HIstory

Have you ever had any of the following heart studies?

- ☐ Electrocardiogram
- ☐ Cardiac catheterization
- ☐ Echocardiogram
- ☐ Treadmill
- ☐ Nuclear Stress Test
- ☐ Cardiac CT

Please check any health condition you currently have or have had in the past:

General
- ☐ Alcoholism
- ☐ Depression
- ☐ Anxiety

Cardiovascular
- ☐ Aortic aneurysm
- ☐ High cholesterol
- ☐ Rheumatic fever
- ☐ Fainting/blackouts
- ☐ High blood pressure

Peripheral vascular
- ☐ Poor circulation-legs
- ☐ Blood clot in legs
- ☐ Raynaud's disease

Respiratory
- ☐ Blood clot in lungs
- ☐ Bronchitis
- ☐ Chronic lung disease
- ☐ Pneumonia
- ☐ Lung cancer
- ☐ Sleep apnea

Gastrointestinal
- ☐ Colon cancer
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Cirrhosis
- ☐ Reflux disease
- ☐ GI bleeding
- ☐ Peptic ulcer

Genitourinary
- ☐ Kidney stones
- ☐ Renal insufficiency
- ☐ Enlarged prostate
- ☐ Prostate cancer

Musculoskeletal
- ☐ Cervical disc disease
- ☐ Gout
- ☐ Lupus
- ☐ Lumbar disc disease
- ☐ Rheumatoid arthritis
- ☐ Orthopedic problems
- ☐ Osteoporosis
- ☐ Osteoarthritis

Neurologic
- ☐ Stroke
- ☐ Mini-stroke

Heme/Lymph
- ☐ Anemia

Skin
- ☐ Skin cancer

Endocrine
- ☐ Hypothyroidism
- ☐ Diabetes
- ☐ High cholesterol

Past Surgical History

List the date and type of any surgeries you have had:

Date Surgery

_____

_____

_____

_____

_____

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Family History

Do you have a history of heart disease in your family? Yes ☐ No ☐

	Age (or age of death)	Health status if living	Cause of death
Mother			
Father			
Sibling			
Sibling			
Sibling			

ALLERGIES

Are you allergic to X-ray Dye? Yes ☐ No ☐

Please list all allergies in the space below:

CURRENT MEDICATIONS

Name of Medication	Dosage	Frequency

Review of Systems Name: _____ Date: _____

Please circle yes or no, if you have had any of the below symptoms <u>since your last office visit</u>

Constitutional

Fevers	Yes	No
Weight Loss	Yes	No
Weight Gain	Yes	No

HEENT

Hearing Loss	Yes	No
Vision Loss	Yes	No

Cardiovascular

Chest Pain	Yes	No
Palpitations	Yes	No
Sweating	Yes	No
Fainting	Yes	No

Respiratory

Coughing Up Blood	Yes	No
Difficulty Breathing	Yes	No
Pauses in breathing	Yes	No
Bluish discoloring to skin/mouth	Yes	No

Gastrointestinal

Bloody Stools	Yes	No
Nausea	Yes	No
Heartburn/ Acid Reflux	Yes	No

Genitourinary

Night Time Urination	Yes	No
Blood in Urine	Yes	No
Low urine output	Yes	No

Musculoskeletal

Joint Pain	Yes	No
Recent Muscle Aches	Yes	No

Dermatology

Rash	Yes	No
Skin Sores	Yes	No

Neurologic

Seizures	Yes	No
Memory Loss	Yes	No
Dizziness	Yes	No

Psychiatric

Depression	Yes	No
Hallucinations	Yes	No

Endocrine

Goiter	Yes	No
Tremor	Yes	No

Heme/Lympha

Acute Anemia	Yes	No
Decreased platelet count	Yes	No
Bleeding easily	Yes	No

Vascular

Hip/Calf pain when walking	Yes	No
Swelling of feet and legs	Yes	No