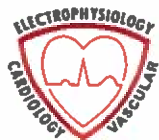

Consultants in Cardiology & Electrophysiology LLC

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Name:____ Date:____________________
(Last) (First) (Middle)

Patient phone: ________________________________ Cell #: ________________________

Date of Birth:__________ Age:_____ Referring Doctor:__________________ Occupation:________________

MEDICAL HISTORY

Please list all the prescription and non-prescription medications you are currently taking:

MEDICATIONS	DOSE(mg)	FREQUENCY	START DATE

Do you have any allergies? YES( ) NO( ) If yes, please list them with type of reaction:________________

Please indicate whether or not you have had any of the following conditions:

INDICATE	YES	NO	INDICATE	YES	NO
CHEST PAIN / ANGINA			GOUT		
CORONARY ARTERY DISEASE			DIZZINESS / FAINTING		
HEART MURMUR			EPILEPSY		
HEART ATTACK			ANXIETY		
BYPASS SURGERY			GLAUCOMA / EYE DISORDERS		
ANGIOPLASTY (BALLOON)			THYROID DISEASE OR PROBLEM		
ROTOBLATOR			SHORTNESS OF BREATH		
STENT			ASTHMA		
HEART VALVE SURGERY			COPD / EMPHYSEMA		
CAROTID BLOCKAGE			PEPTIC ULCER		
LEG CIRCULATION PROBLEMS			PANCREATITIS		
STROKE / TIA			GALL BLADDER DISEASE		
CONGENITAL HEART DISEASE			LIVER DISEASE, JAUNDICE, HEPATITIS		
RHEUMATIC HEART DISEASE			INTESTINAL PROBLEM (COLITIS), ETC.		
CONGESTIVE HEART FAILURE			KIDNEY DISEASE		
HEART PALPITATIONS			URINARY PROBLEMS		
LEG PAIN WHILE WALKING			FATIGUE		
ANEURYSM			ANEMIA		
PACEMAKER OR DEFIBRILLATOR			BLEEDING DISORDER		
HIGH CHOLESTEROL			ARTHRITIS		
HIGH TRIGLYCERIDES			CANCER		
HIGH BLOOD PRESSURE			HIV / AIDS		
DIABETES			PSYCHIATRIC PROBLEMS		

Other: *(Please make any comments in regards to the above):*
Please list any other medical problems you may have: ____________________________________

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18210 S. LaGrange Road, Suite 102
Tinley Park, Illinois 60477
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Hospitalization History

Please list any hospitalizations within the last two years:

NAME OF HOSPITAL	DATE(S)	REASON FOR HOSPITALIZATION

Gynecological History *(Women only):*

Have you had a hysterectomy? YES( ) NO( )
Have you gone through menopause? YES( ) NO( ) Date of Last Menstrual Period__________________
Do you take hormone replacement? YES( ) NO( )

Surgical History

NAME OF OPERATION	DATE	COMPLICATION (IF ANY)

Patient Profile

Do you smoke: YES( ) NO( ) Quit: __________ How long ago? ____________
If yes or quit, how much do (or did) you smoke per day? __________
How long have *(or had)* you been smoking? ____________________

Do you drink alcoholic beverages? YES( ) NO( )
If yes, how many ounces do you average per week? _____Oz. Liquor _____Oz. Wine _____Oz. Beer

Do you use *(or have you used)* illegal drugs? YES( ) NO( )
Do you use *(or have you used)* intravenous drugs? YES( ) NO( )
Date last used: ________________

Do you exercise regularly: YES( ) NO( ) How long/often?____________________
What do you do? ________________ How long: _________ How often?____________________
How much caffeine do you consume daily? *(cups of coffee, tea, soda)*____________________

Family History

Have any of your family members had any of the following problems:
(Please use (M) Mother, (F) Father, (S) Sister, (B) Brother, (C) Children)

PROBLEM	FAMILY MEMBER(S) AND AGE OF ONSET FOR EACH
STROKE	
HEART ATTACK	
HEART BYPASS SURGERY/ANGIOPLASTY/STENT	
DIABETES	
HIGH BLOOD PRESSURE	
CHOLESTEROL/TRIGLYCERIDES	
LEG CIRCULATION PROBLEMS	
CAROTID (NECK) BLOCKAGE	

Please add any pertinent family history:

____

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Date ________________ MD who referred ________________________

Name: ____ ____/____/____
First Middle Last DOB

Address: ____________________________________ ______________________
Street Number Marital Status

____________________________________ Phone# (1) ______________
City State Zip

Phone# (2) ______________

Employer: ______________________________ Date Retired______________

Social Security: ______________________________ Phone # ______________

Address: ____

Emergency contact ______________________________ Phone #______________

OTHER INSURED INFORMATION

Name ______________________ DOB ______________ Relationship ______________

Address ______________________ City ____________ State __________ Zip__________

Phone (____) ______________________ Social Security # ______________ Marital Status__________

Employer ______________________ Occupation______________________________

Address ______________________ City ____________ State __________ Zip __________

Phone (___) ______________________ # of employees at place of employment: <20 ________>20__________

INSURANCE INFORMATION

Primary Carrier: ______________________ ID#: ______________ GR#:______________

Subscriber ______________________ Relationship ______________________

PPO ☐ HMO ☐ REFERRAL NEEDED ☐ YES ☐ NO Specialist Co-Pay amount $______________

Secondary Insurance ______________________ ID # ______________ Gr. #______________

Subscriber ______________________ Relationship ______________________

PPO ☐ HMO ☐ REFERRAL NEEDED ☐ YES ☐ NO Specialist Co-Pay amount$______________

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MEDICARE: Your claim will be filed automatically and our office reimbursed directly. We are a participating physician and assignment is accepted. If you have a Medigap policy as a secondary insurance, that will be filed also. Otherwise, payment of any deductible and/or co-insurance is due at the time of service.

_______ Initial

PPO: Insurance will be filed on your behalf. However, any co-payment and/or deductible is due at the time of service.

_______ Initial

HMO: Insurance will be filed on your behalf only if a Preauthorization Form from your primary physician is presented at the time of your visit. However, any co-payment and/or deductible is due at the time of service. If we do not have a Preauthorization Form and authorization cannot be obtained, payment in full for your visit is expected at the time of service.

_______ Initial

ALL OTHER INSURANCE: Payment in full is due at the time of service unless prior arrangements have been made with our office. We will provide you with a completed claim form in approximately one week from your visit which you can send directly to your carrier for reimbursement.

_______ Initial

Benefits vary and your insurance may pay all, some or none of your bill. Please become familiar with your insurance coverage, as you are responsible for paying any charges not covered by your carrier.

CONSULTANTS IN CARDIOLOGY & ELECTROPHYSIOLOGY, LLC

PHYSICIANS ASSIGNMENT OF BENEFITS

AND AUTHORIZATON TO RELEASE INFORMATION

I hereby authorize the submitting physician to release any information acquired in the course of my examination or treatment necessary to process insurance claims.

I assign any benefits payable by my insurance carrier to the provider of services submitting a bill for services rendered.

X ____
Signature of Patient

X ____
Signature of Insured

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