Lansing Cardiovascular Consultants, P.C.

Same Day HeartCare
YOUR CARDIOLOGY CLINIC, ON DEMAND

PATIENT REGISTRATION INFORMATION

PLEASE PRINT AND COMPLETE ALL SECTIONS OF THIS FORM

LAST NAME_____ FIRST NAME_____ INITIAL _____

DATE OF BIRTH _____ SEX ❑ M ❑ F SOCIAL SECURITY _____

MARITAL STATUS ❑ S ❑ M ❑ W ❑ D ❑ Other_____

ADDRESS _____ CITY_____ STATE_____ ZIP _____

HOME PHONE _____ CELL _____ EMAIL ADDRESS _____

SPOUSE NAME _____ INSURANCE COMPANY_____

RACE ❑ White ❑ Black ❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ American Indian/Alaskan Native ❑ Hispanic ❑ Other

ETHNICITY ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Unreported/Refused

LANGUAGE ❑ English ❑ Spanish ❑ French ❑ Arabic ❑ Chinese ❑ Sign Language

EMPLOYER _____ WORK PHONE _____

Responsible Party Information *(for patients under 18 and other dependent patients)*

Name:_____ Relationship to patient:_____
Last First Middle Initial

Address:_____ City:_____ State:_____ Zip:_____

DOB:_____ **Sex**: ❑F ❑M Phone:_____ ❑Home ❑Cell ❑Other
MM/DD/YYYY

Emergency Contact

Name:_____ Phone:_____ Relationship to patient:_____

Patient's Insurance Information

Primary Policy:_____

Policy Holder:_____

Date of Birth:_____

Relationship to Patient:_____

Secondary Policy:_____

Policy Holder: _____

Date of Birth: _____

Relationship to Patient: _____

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Patient Registration Form (Continued)

Assignment of Benefits

I authorize Patient Central via Lansing Cardiovascular Consultants, P.C. to release such information from my patient records as is required in order to receive reimbursement for any billings rendered relating to my treatment. I request that payment be made either to me or to Lansing Cardiovascular Consultants, P.C. for medical services provided to me. In making this authorization I understand and agree to pay any unpaid balance to include deductible and coinsurance if applicable.

➡ _____ _____

Signature of Patient or Legal Guardian Date

Acknowledgment of Notice of Privacy Practices

The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy is available to you upon request.

➡ _____ _____

Signature of Patient or Legal Guardian Date

*****For Medicare Patients Only*****

I request that payment of authorized Medicare benefits be made on my behalf to Lansing Cardiovascular Consultants, P.C. and/or Patient Central for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

Patient's MEDICARE Number (HIC)_____

By signing below, I agree to the above communication preferences, privacy practices, as well as assignment of benefits.

➡ _____ _____

Signature of Patient or Legal Guardian Date

CARDIOVASCULAR AND MEDICAL HEALTH REVIEW

NAME _____ DATE _____ WEIGHT _____ HEIGHT _____ DATE OF BIRTH ____/____/____

PERSONAL HISTORY
PLEASE CIRCLE

SINGLE MARRIED PARTNER DIVORCED WIDOWED
SMOKER FORMER SMOKER NEVER SMOKED
SMOKELESS TOBACCO USER E-CIGARETTE
ALCOHOL USE: DAILY OCCASIONAL RARE NEVER
EMPLOYED UNEMPLOYED DISABLED RETIRED

PAST HEART HISTORY

HAVE YOU HAD?	YES	NO	YEAR
Heart attack	❑	❑	_____
Balloon angioplasty	❑	❑	_____
Heart stents	❑	❑	_____
Heart bypass	❑	❑	_____
Leg stents or bypass	❑	❑	_____
Carotid stents or surgery	❑	❑	_____
Renal/digestive artery stent	❑	❑	_____
Vein stripping or ablation	❑	❑	_____
Pacemaker implanted	❑	❑	_____
ICD implanted	❑	❑	_____

Other cardiovascular event/procedure _____

_____

Do you see other doctors for heart or circulation issues?

_____

SYMPTOMS AND RISK FACTORS

DO YOU HAVE OR HAD RECENTLY:	Y	N	WHEN
Chest pain	❑	❑	_____
Shortness of breath	❑	❑	_____
Angina	❑	❑	_____
Palpitations or racing heart	❑	❑	_____
Atrial fibrillation	❑	❑	_____
Bleeding or clotting disorder	❑	❑	_____
Fainting or blackouts	❑	❑	_____
Leg pain while walking	❑	❑	_____
Varicose veins	❑	❑	_____
Leg swelling, heaviness or fatigue	❑	❑	_____
Leg itching, burning or throbbing	❑	❑	_____
Leg cramps, swelling or restlessness	❑	❑	_____
Blood clots in the legs or lungs	❑	❑	_____
Do problems with your legs interfere with your lifestyle or limit your activities?	❑	❑	_____
Have you had a stroke or mini stroke	❑	❑	_____
Sudden visual changes	❑	❑	_____
Black areas in your vision	❑	❑	_____
Numbness	❑	❑	_____
Stumbling or loss of balance	❑	❑	_____
Abdominal aortic aneurysm	❑	❑	_____
Family history of aortic aneurysm	❑	❑	_____
Have you had a screening test for aortic aneurysm		Y	N
Have you had a screening test for carotid blockage		Y	N
Smoking or history of smoking	❑	❑	
High cholesterol	❑	❑	
High Blood pressure	❑	❑	
Diabetes	❑	❑	
Family history of heart disease or stroke	❑	❑	

OTHER MEDICAL CONDITIONS

DO YOU HAVE?	Y	N	DETAILS
Thyroid disease	❑	❑	_____
Lung disease	❑	❑	_____
Stomach/digestive	❑	❑	_____
Liver problem	❑	❑	_____
Kidney problem	❑	❑	_____
Brain/neurological	❑	❑	_____
Muscle disease	❑	❑	_____
Cancer	❑	❑	_____

OTHER MEDICAL CONDITIONS?

_____
_____
_____

SURGERY

SURGERY	DATE

ALLERGIES

ALLERGY	REACTION

MEDICATIONS

MEDICATION	DOSE	FREQUENCY

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Protected Health Information Patient Preferences

Please help us accommodate your wishes regarding how we communicate with you about your health care by completing and signing this form.

❑ Yes ❑ No May we use your first name, last name, or both to identify you in the waiting room? If not, how would you prefer to be identified?

_____

❑ Yes ❑ No May we leave a message on your answering machine or voicemail reminding you of an appointment, or requesting that you call our office? If not, is there an alternate method of contacting you by phone?
❑ Email ❑ Cell ❑ Text ❑ Other

_____

❑ Yes ❑ No May we leave information regarding an upcoming appointment or a request for you to call us with another individual in your household?

❑ Yes ❑ No May we send written correspondence in a sealed envelope to your home address? If not, is there an alternative address where we may send confidential communications to?

_____

❑ Yes ❑ No Is there another person with whom you give permission for us to speak with about your health care? If yes, please list name(s) and relationship.

_____

_____

_____

Please list any physicians you would like copies of office notes and test results sent to.

_____

_____

_____

_____

➡ _____ _____

Signature of Patient or Legal Guardian Date