

PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Gender _____

Social Security: _____ Date of Birth: _____

Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

Phone #: (H): _____ (Mobile): _____ (Work): _____

Email: _____ Marital Status: Married _____ Single _____ Other _____

Translator Required: Y/N. If Yes, specify Language: _____

Employment: Full Time _____ Part Time _____ Retired _____ Not Employed _____ School _____

Employer: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip _____

SPOUSE INFORMATION

Last Name: _____ First Name: _____ MI: _____ Gender _____

Phone #: (H): _____ (Mobile): _____ (Work) _____

Social Security: _____ Date of Birth: _____

Employer: _____

PARENT INFORMATION

(This section is only applicable to full time students or for individuals covered under parents/guardian's insurance policy. Please provide the below information on the parent in which you are covered under)

Parent Last Name: _____ First Name: _____ MI: _____ Gender: _____

Social Security: _____ Date of Birth: _____

Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

Phone #: (H): _____ (Mobile): _____ (Work): _____

Employer: _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____ Gender _____

Relationship to Patient: _____ Primary Number: _____ Secondary Number: _____

PRIMARY CARE PHYSICIAN

REFERRING PHYSICIAN (If not Primary Care Physician)

Physician Name: _____	Physician Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone Number: _____	Phone Number: _____
Fax: _____	Fax: _____

PHARMACY INFORMATION

Name of Pharmacy: _____

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

Phone #: _____ (Fax): _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: _____

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

Subscriber ID #: _____ Group #: _____

Patient's relationship to insured: Self/Spouse/Child/Other

Insured Name (if not self): _____ SS#: _____ Date of Birth: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name: _____

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

Subscriber ID #: _____ Group #: _____

Patient's relationship to insured: Self/Spouse/Child/Other

Insured Name (if not self): _____ SS#: _____ Date of Birth: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE

Please check One: Referring Physician: _____ Friend/Relative: _____ Insurance Manual: _____ Brochure/Ad: _____

Radio/TV: _____ Phone Book _____ Internet _____ Other: _____

Billing Policy

Referrals:

It is the patient's responsibility to obtain referrals for initial and follow up visits, which must be presented to the receptionist prior to your visit. If you do not have out of network benefits and you choose to be seen without a referral, you will be responsible for payment of all services. If you choose to use your out of network benefits, arrangements must be discussed with our Billing Coordinator prior to your visit.

Workman's Compensation/No Fault Insurance:

Arrangements with our billing department must be made prior to your visit. Please contact them prior.

Copayments:

All copayments /coinsurance payments are due at the time of your visit.

Medicare:

We are participating providers of Medicare. Patients are responsible for 20% Medicare coinsurance and/or deductible (if applicable) UNLESS paid by your secondary insurance carrier. If your secondary carrier does not cover your coinsurance in full, you will be billed for the balance.

Medicare HMO:

If you are planning to join or have joined a Medicare HMO plan, you must notify our office/billing department so that we can update your records.

Insurance Policy:

It is the responsibility of the patient/insured to know the terms of their insurance coverage. Deductible/coinsurance withheld from payments is the patient's responsibility. Payments denied due to lapse of coverage/termination, misrepresentation of information **or failure to notify us of changes to your insurance, are the patient's responsibility.**

If you have any further questions or concerns regarding any of the above policies, please feel free to contact our Billing Department/Coordinator with any questions you may have.

I verify the accuracy of the above information. I authorize the disclosure of my medical information and that payment for authorized services is made to the treating physician at Long Island Heart Associates on my behalf.

Signature of Patient: _____ **Today's Date:** _____

Print Name: _____

PATIENT’S AUTHORIZATION SIGNATURE FORM FOR ASSIGNMENT OF BENEFITS

MEDICARE PART B

“I Request that payment of all authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.”

ALL OTHER INSURANCES

“I hereby authorize any physician, health care practitioner, hospital, clinic or other medical or medically related facility to furnish any and all records, medical history, and services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my insurance company.

I also authorize my insurance company to disclose to a hospital or health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of the claim.

If my coverage is under Group Contract held by an employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurance company including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators.”

FINANCIAL RESPONSIBILITY: I do hereby expressly guarantee payment in full of any and all charges in consideration for services rendered by Long Island Heart Associates. This includes but is not limited to, any charges considered by my insurance company or Medicare to be “non-covered services.

Patient (or Authorized) Name: _____

Patient (or Authorized) Signature: _____

Health Insurance Claim Number: _____

Date: _____

LONG ISLAND HEART ASSOCIATES RISK FACTORS FOR CORONARY DISEASE

Patient Name: _____ Date Of Birth: _____

Medications	Dose	Amt Per Day	Years Taken

Allergies

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING RISK FACTORS:

ELEVATED CHOLESTEROL: YES _____ NO _____ NOT SURE _____	LAST TEST DATE: _____	HDL _____	LDL _____
SMOKER: YES _____ NO _____	YEARS SMOKED: _____	# OF PACKS PER DAY: _____	YEARS QUIT: _____
HIGH BLOOD PRESSURE: YES _____ NO _____	DIABETES: YES _____ NO _____	TYPE 1 _____	OR TYPE 2 _____

MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING?

STRESS TEST	YES _____ NO _____	YEAR _____	NORMAL/ABNORMAL _____
HEART ATTACK	YES _____ NO _____	YEAR _____	
CARDIAC CATHERIZATION	YES _____ NO _____	YEAR _____	
CORONARY ANGIOPLASTY	YES _____ NO _____	YEAR _____	
STROKE OR TIA (MINISTROKE)	YES _____ NO _____	YEAR _____	
CAROTID ARTERY SURGERY	YES _____ NO _____	YEAR _____	
POOR CIRCULATION TO LEGS	YES _____ NO _____		
BYPASS SURGERY	YES _____ NO _____	YEAR _____	HOSPITAL: _____
ANGIOPLASTY OF LEGS	YES _____ NO _____	YEAR _____	
DO YOU EXERCISE REGULARLY	YES _____ NO _____ OCCASIONALLY _____		
TYPE OF ACTIVITY:	HOURS PER WEEK:		
WALKING	0-2 _____ 3-4 _____	5-6 _____	7-8 _____ 9+ _____
RUNNING	0-2 _____ 3-4 _____	5-6 _____	7-8 _____ 9+ _____
BICYCLING	0-2 _____ 3-4 _____	5-6 _____	7-8 _____ 9+ _____
SWIMMING	0-2 _____ 3-4 _____	5-6 _____	7-8 _____ 9+ _____
TENNIS	0-2 _____ 3-4 _____	5-6 _____	7-8 _____ 9+ _____
OTHER: _____	0-2 _____ 3-4 _____	5-6 _____	7-8 _____ 9+ _____

Patient Signature: _____ Date: _____

Patient Name: _____ Date Of Birth: _____

FAMILY HISTORY/SOCIAL HISTORY

IN YOUR FAMILY IS THERE A HISTORY OF?

HEART ATTACKS: YES _____ NO _____ RELATIONSHIP _____ AGE AT FIRST ATTACK _____
AGE AT DEATH _____ IF MORE THAN ONE FAMILY MEMBER, PLEASE SPECIFY: _____

CORONARY ANGIOPLASTY: YES _____ NO _____ RELATIONSHIP _____ AGE AT FIRST ATTACK _____
AGE AT DEATH _____ IF MORE THAN ONE FAMILY MEMBER, PLEASE SPECIFY: _____

CORONARY ANGIOPLASTY: YES _____ NO _____ RELATIONSHIP _____ AGE AT FIRST ATTACK _____
AGE AT DEATH _____ IF MORE THAN ONE FAMILY MEMBER, PLEASE SPECIFY: _____

CARDIAC PROFILE (COMPLETE ONLY IF YOU HAVE EVER HAD CHEST DISCOMFORT)

DO YOU HAVE DISCOMFORT?

WHEN YOU WALK UPHILL OR HURRY YES _____ NO _____ DON'T KNOW _____

WHEN YOU WALK AT AN ORDINARY PACE YES _____ NO _____ DON'T KNOW _____

AT REST YES _____ NO _____ DON'T KNOW _____

WHAT DO YOU DO WHEN IT HAPPENS IF YOU ARE WALKING? PLEASE SPECIFY:

IF YOU STAND STILL WHAT HAPPENS? NOTHING _____ GOES AWAY _____

HAVE YOU EVER HAD PAIN ACROSS THE FRONT OF YOUR CHEST LASTING ½ HOUR OR MORE? YES _____ NO _____

DID YOU SEE THE DOCTOR BECAUSE OF THIS PAIN? YES _____ NO _____

WHAT DID THE DOCTOR SAY IT WAS? ANGINA _____ HEART ATTACK _____ NOT SURE _____ OTHER: _____

HAVE YOU HAD CHEST DISCOMFORT IN THE PAST WEEK? YES _____ # OF EPISODES _____ NO _____

PLEASE LIST ANY MEDICATIONS/VITAMINS/HORMONE SUPPLEMENTS YOU ARE TAKING? IF NONE, PLEASE INDICATED NONE TAKEN. IF YOU ARE PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION: NAME OF MEDICATION, DOSE, HOW OFTEN, HOW MANY YEARS TAKEN

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from 3rd party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____

I allow my records to be released to: _____

Relationship to Patient: _____

Patients Signature: _____

Date: _____