Printed Name: ________________________________________ Patient ID:________________

________________
Date of Appointment

**New Patient Questionnaire**

**Reason for visit:** ________________________________________________________________________

**Please list All Allergies/ Sensitivities with reactions:**

| Drug | Reaction(s) |
|---|---|
| | |
| | |
| | |
| | |

**Please list All medications you are taking:**

| Medication | Dosage | How many times per Day |
|---|---|---|
| | | |
| | | |
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| | | |

Printed Name: ________________________________________ Patient ID:________________

## PAST MEDICAL HISTORY

**Please list Past Medical Illnesses:** ____________________________________________________________

______________________________________________________________________________

**Cardiovascular Illnesses:** ____________________________________________________________

______________________________________________________________________________

**Please list past procedures/ testing:**

| | Type | Date(*s*) | Location |
|---|---|---|---|
| **Surgeries/ Procedures *(non cardiac)*** | | | |
| | | | |
| | | | |
| | | | |
| **Cardiology Procedures *(Invasive)*** | | | |
| Bypass Surgery | | | |
| Stent Placement | | | |
| Heart Cath | | | |
| Cardiology Procedures *(Non- Invasive)* | | | |
| Stress Testing | | | |
| Echocardiogram (Ultrasound of heart) | | | |
| Holter/ Event Monitor | | | |
| **Electrophysiology Procedures** | | | |
| | | | |
| **Device Implants** | | | |
| Pacemaker/Defibulator | | | |
| **Peripheral Vascular Procedures** | | | |
| | | | |

## CARDIAC RISK FACTOR SCREENING

History of Tobacco Use: □ **YES** □ **NO**

Family history of Heart Disease**:** □ **YES** □ **NO**

History of Hyperlipidemia (*high cholesterol*)**:** □ **YES** □ **NO**

History of Hypertension (*High blood pressure*)**:** □ **YES** □ **NO**

History of Diabetes Mellitus**:** □ **YES** □ **NO**

Prior History of Heart Disease**:** □ **YES** □ **NO**

Printed Name: ________________________________________ Patient ID:________________

## SOCIAL HISTORY

Alcohol use: ☐ **YES** ☐ **NO**

- If yes, number of alcoholic drinks/day _______
- Do you ever drink more: ☐ **YES** ☐ **NO**

Smoking/ Tobacco Use:

☐ **Never smoked** ☐ **Stopped** (date): _________ ☐ **Current Smoker**: _______packs/day ______cigars/day

Caffeine Use: ☐ **YES** ☐ **NO**

- If yes, number of caffeinated drinks/day _______
- Do you ever drink more: ☐ **YES** ☐ **NO**
- If yes, number of decaffeinated drinks/day _______
- Do you ever drink more: ☐ **YES** ☐ **NO**

Exercise: ☐ **YES** ☐ **NO**

- If yes, how often: ☐ daily ☐ ________ times/week
- type of exercise: ____________________________________________

## Miscellaneous

**Race**: ☐ American Indian or AK Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or other Pacific Island ☐ White

**Ethnicity:** ☐ Hispanic or Latino ☐ NON-Hispanic or Latino

**Preferred Language:** ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Hebrew ☐ Italian ☐ Japanese ☐ Korean ☐ Portuguese ☐ Russian ☐ Spanish ☐ Swahili

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Please feel free to include any other information which may be pertinent to your care: ________________________

____________________________________________

____________________________________________

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____________________________________________

Printed Name: ________________________________________ Patient ID:________________

Cardiovascular Consultants of Southern Delaware
Patient Privacy Questionnaire

1. Please list the name and phone number of a family member or other person, *if any*, who we may inform

   About your general medical condition and diagnosis: □ **NONE** or please PRINT other: _____________

   ________________________________________________________________________

2. Please list the name and phone number of a family member or other person, *if any*, who may be authorized to discuss your billing statement: □ **NONE** □ **SAME AS ABOVE** or please PRINT other:

   ________________________________________________________________________

3. Please list the name and phone number of a family member or other person, if any, who we may contact in

   An emergency: □ **NONE** □ **SAME AS ABOVE** or please PRINT other: ___________________________

   ________________________________________________________________________

4. Please PRINT the address where you would like your billing statement sent:

   □ **SAME AS MY REGISTRATION ADDRESS** or please PRINT other: ____________________________

   ________________________________________________________________________

5. Please PRINT the address of where you would like the other correspondence from our office sent:

   □ **SAME AS MY REGISTRATION ADDRESS** or please PRINT other: ____________________________

   ________________________________________________________________________

6. Other than your home phone number, please print the telephone number, if any, where you want to receive

   calls about your appointments, lab results, x-rays, or other health care information: __________________

   ________________________________________________________________________

7. Can confidential messages be left on your home answering machine or voicemail: □ **YES** □ **NO**
8. Can confidential messages be left at your place of employment: □ **YES** □ **NO**

____________________________________________________________ __________________

Patient/ Legal Guardian Signature date

**************** **All correspondence that is mailed will be marked "Personal and confidential"** ******************

CARDIOVASCULAR CONSULTANTS OF SOUTHERN DELAWARE, LLC

Barry S. Denenberg, M.D., FACC
R. Alberto Rosa, M.D., FACC
Kenneth P. Sunnergren, M.D., FACC
G. Robert Myers, M.D.
Heather Raff, M.D.
Peggy A. Bixler, MSN, ACNP-BC

16704 Kings Highway, Lewes, DE 19958
(302) 645 1233 phone/ (302) 645 1228 fax

35141 Atlantic Avenue #3, Millville, DE 19967
(302) 514 8138 phone/ (302) 541 8425 fax

Patient ID:________________

# Medical Records Release

**To:** ____________________________________________ **Date:** _________________________

I hereby authorize you to use or disclose the specific information described below, only for the Purpose and parties also described below:

□ Medical Records only □ Include mental health records

□ Include drug and alcohol records □ Include STD records

□ Include HIV records □ Include genetic information records

*Entity requesting the information and authorized to make the requested use:*

**Cardiovascular Consultants of Southern Delaware**

□ Lewes, 16704 Kings Highway, Lewes, DE 19958, (302) 645 1233(p); (302) 645 1228(f)

□ Millville, 35141 Atlantic Avenue, Unit 3, Millville, DE 19970, (302) 541 8138(p); (302) 541 8425(f)

This information is being requested for the following purpose(s):

□ Medical Treatment □ Legal Proceeding □ Insurance Purposes □ Other: ______________________

This authorization shall remain in effect from the date signed below until: ______________(expiration date/event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by The recipient and no longer is protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research/ related treatment, in which case you may refuse to provide that research-related treatment)

I acknowledge that I have received the "Notice of Privacy Practice" and authorize **CVCSD** to release or obtain my private information for the purposes of my treatment, to obtain payment from a third party or conduct normal healthcare operations, per the Health Insurance Portability and Accountability Act of 1996.

PRINTED Patient Name: _____________________________________ Last Four digits of Social Security: ________

Signature: ______________________________________________ Date of Birth: ________________________

*If signed by personal representative, please include printed name and relationship:* ____________________________________

CARDIOVASCULAR CONSULTANTS OF SOUTHERN DELAWARE, LLC

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Patient ID:________________

## Financial Policy Effective March 14th, 2011

**Appointment Cancellation/ No-Show:**

- If you are unable to keep your scheduled appointment for any reason, please call and inform us At least 24 hours in advance. If you fail to do so, we may charge fees to commensurate with our Costs.
- In particular, patient scheduled for office visits will be charged $30. Normally, insurance will **NOT cover** these costs, and will **NOT** be billed. Patients scheduled for any type of Cardiac Diagnostic testing will be charged $100, unless the appointment(s) are cancelled or rescheduled At least 24 hours before the test.

**Appointment Rescheduling:**

- Cardiology is a field prone to life and death emergencies. Our providers have a solemn Obligation to prioritize care in these situations. We appreciate your understanding and will Try to accommodate your needs as best as we can.

**Financial Responsibility:**

- I acknowledge that Cardiovascular Consultants of Southern Delaware(CVCDE) may bill my Insurance carrier as a courtesy to me; however, the financial responsibility for any and all Charges incurred during my treatment is mine. In consideration of the services rendered, I authorize payment directly to CVCDE. I also acknowledge that I have received the "Notice Of Privacy Practice" and authorize CVCDE to release my private information for the purposes Of my treatment, to obtain payment from third party or conduct normal healthcare operations, Per the Health Insurance Portability and Accountability Act of 1996.

## STATEMENT OF FINANCIAL RESPONSIBILITY

I acknowledge that Cardiovascular Consultants of Southern Delaware may bill my insurance as a courtesy to me, But the financial responsibility for any and all charges incurred during my treatment is mine. In consideration of the services rendered, I promise to pay Cardiovascular Consultants of Southern Delaware the full amount of charges for said services upon demand or in accordance with payment arrangements agreed to by them.

## INSURANCE AUTHORIZATION AND ASSIGNMENT LIFETIME AUTHORIZATION

**ASSIGNMENT OF BENEFITS:**

I herby authorize payment to CARDIOVASCULAR CONSULTANTS OF SOUTHERN DELAWARE. The benefits due me for services rendered.

**I understand the above information and agree to comply with the above policies: (*please fill out below)***

PRINTED Patient Name: ________________________________________ Last Four digits of Social Security: _________

Signature: _____________________________________________________ Date of Birth: ________________________

*If signed by personal representative, please include printed name and relationship:* _________________________________

CARDIOVASCULAR CONSULTANTS OF SOUTHERN DELAWARE, LLC

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Patient ID:________________

**Medicare/ Medigap Authorization and Assignment**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Cardiovascular Consultants** for any services furnished me by **Cardiovascular Consultants**. Regulations pertaining to Medicare assignment of benefits apply.

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Should this claim not be paid in full by myself or by the insurance company (according to Medicare participatory rule) then I will be responsible for any reasonable collection expenses and attorney fees required to secure full payment.

____________________________________ __________________ _______
Signature of Subscriber or Beneficiary Identification Number Date

____________________________________ __________________
Printed Name of Subscriber or Beneficiary Date of Birth

---

**Medigap Authorization Statement**

I authorize any holder of medical information about me to release to **Cardiovascular Consultants** any information needed for this or a related Medigap claim, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

SIGNATURE________________________________________ DATE____________

Policy Number:________________________________