Cardiovascular Consultants New Patient Questionnaire **Date of Appointment:** _____

Patient Name: _____ Patient ID:_____

Mailing Address: _____

Email address: _____ @ _____

Best Phone number to reach you: _____ Alternate: _____

Are you currently employed: ☐ YES ☐ NO

Primary Care Physician *(most insurance companies require a PCP)*: _____

Reason for visit: _____

Please list All Allergies/ Sensitivities with reactions: (*If additional room is needed, please use back of page*)

Drug	Reaction(s)

Local Pharmacy: _____ **Mail In Pharmacy:** _____

Please list All medications you are taking: (*If additional room is needed, please use back of page*)

Medication	Dosage	How many times per Day

Patient 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/Defibrillator			
Peripheral Vascular Procedures			

Cardiac Risk Factor Screening	**YES**	**NO**	
Prior History of Heart Disease**:**			
Family history of Heart Disease			
History of Hyperlipidemia (*high cholesterol*)**:**			
History of Hypertension(*High blood pressure*)**:**			
History of Diabetes Mellitus**:**			
Social History	**YES**	**NO**	
Alcohol use			If yes, number of alcoholic drinks/day _____ ● Do you ever drink more: □ **YES** □ **NO**

**Social History Continued on next page*

Patient Name: _____ Patient ID:_____

Social History	**YES**	**NO**		
Smoking/ Tobacco Use	□ **Current** Number of packs/cigars per day ____	□ **NEVER**	□ **Quit/ date:**_____	
Caffeine Use			● 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			● If Yes, How often: _____ times/daily _____ times/weekly ● Type of exercise: _____	
Miscellaneous				
Race	□ American Indian or AK Native □ Hispanic	□ Asian □ Native Hawaiian or other Pacific Island	□ Black or African American □ White □ Other: (*Please specify*): _____	
Ethnicity	□ Hispanic or Latino	□ NON-Hispanic or Latino		
Preferred Language	□ English	□ Spanish	□ Other: (*Please specify*): _____	
Marital Status	□ Single	□ Married	□ Widowed	□ Divorced

Please feel free to include any other information which may be pertinent to your care:
(***If additional room is needed, please use back of page***)

_____

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_____

Patient Name:_____ Patient ID:_____

Cardiovascular Consultants of Southern Delaware
HIPAA 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, medical diagnosis, appointments and billing statement:

   □ **NONE** OR Please enter below:

   Name: _____

   Phone number: _____

   Relationship: _____

   Name: _____

   Phone number: _____

   Relationship: _____

   Name: _____

   Phone number: _____

   Relationship: _____

2. Can confidential messages be left on your home answering machine or voicemail: □ **YES** □ **NO**

3. Can confidential messages be left at your place of employment:□ **YES** □ **NO** □ **Retired** □ **Unemployed**

4. 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.

_____ _____
Patient/ Legal Guardian Signature date

Barry S. Denenberg, MD, FACC
R. Alberto Rosa, MD, FACC
Kenneth P. Sunnergren, MD, FACC
G. Robert Myers, MD, FACC
Ajith Kumar, MD
Penny F. Johnson, DNP, CRNP

Cardiovascular Consultants of Southern Delaware

Patient ID: _____

Date: _____

Financial Policy Effective Jan 1, 2017

Please sign the statement at the bottom of the page, to acknowledge your understanding in its entirety.

Appointment Cancellation:
Our policy is to charge for any missed appointments that are **not cancelled 24 hours prior** to your appointment. There will be a $25 charge for a missed appointment. These charges will be ***your responsibility*** and billed directly to you. **Insurance will *not* cover** charges for missed appointments.

If you are scheduled for Nuclear Stress Testing and do not cancel/reschedule your appointment within the **required 24 hour advanced notice *you* will be responsible for the $100 fee** associated. This fee is a result of supplies being ordered specifically for your testing that cannot be used/disposed of in the event the order is not canceled.

Referrals:
If you have insurance that requires a referral, you must have your referral prior to receiving treatment. It is your responsibility to obtain all necessary referrals from your primary care physician. Patients without proper referrals who elect to receive service from our providers will be required to make payment in full at the time of service.

Self Pay/Non Covered Services:
We participate in most insurance plans, however it is your responsibility to confirm with your insurance if services rendered will be covered. Our practice, as a courtesy verifies your insurance on file with the insurance agencies but this is not a guarantee of payment.
Patients who are uninsured or have non covered services are expected to pay at the time of service. We offer a 40% discount for paying for your services at the time they are rendered.

Collections:
If your account becomes delinquent you agree to pay any charges to collect your balance due, including court costs, and/or collection agency fees. After being billed 4 statements you will receive a letter stating you have 10 days to pay in full. Payment plans are available but are not to exceed a 12 month time frame, unless otherwise negotiated. You must contact billing to negotiate your payment plan or risk collection. ***Please be aware that if your account becomes delinquent or in a collection status you will be expected to resolve your debt as negotiated with the billing department prior to being able to schedule or keep previously scheduled appointments.***

At the time of EACH visit within the practice, we must obtain a copy of your identification, current insurance card, and social security number in order to file your claim. Copays and outstanding debt are due at check in. Co-insurance and deductibles will be billed after insurance has processed your claim.

Please note, there may be additional fees not covered by your insurance company for the completion of forms and the copying of medical records.

By signing below, I acknowledge having read the above mentioned financial policy:

PRINTED Patient Name: _____

Signature: _____

Last four digits of Social Security: _____ Date of Birth: _____

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

_____

Lewes Office:
16704 Kings Highway
Lewes, De 19958-4929
(302) 645 1233 phone
(302) 645 1228 fax

Millville Office:
35141 Atlantic Avenue, Unit 3
Millville, De 19970-6954
(302)541 8138 phone
(302) 645 1228 fax
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