NEW PATIENT INFORMATION PACKAGE

PATIENT INFORMATION (please print)

❑ Dr. ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Sir

Patient Name (Last): ______ (First): ______ (MI): ______ Previous Name: ______

Address: ______ City: ______ State: ______ Zip Code: ______

Home Phone #: ______ Cell Phone #: ______ Other Phone #: ______

Date of Birth: MM______ /DD______ /YYYY______ Sex: ❑ F - Female ❑ M - Male ❑ Transgender

Email address: ______

Race: ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ White ❑ Declined

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined

Language: ❑ English ❑ Spanish ❑ Indian ❑ Japanese ❑ Chinese ❑ Korean ❑ French ❑ German ❑ Russian ❑ Other

Last grade completed: ______

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Social Security Number: ______ - ______ - ______ Employer Name: ______

Employment Status: ❑ 1 - Full-Time ❑ 2 - Part-Time ❑ 3 - Not Employed ❑ 4 - Self-Employed ❑ 5 - Retired ❑ 6 - Active Military

Student Status: ❑ F - Full-Time Student ❑ P - Part-time Student ❑ N - Not a Student

Emergency Contact: Last Name: ______ First Name: ______ Phone Number: ______

Emergency Contact Relationship to Patient: ❑ Guardian

Address: ______ City: ______ State: ______ Zip Code: ______

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party: ❑ Another ❑ Patient ❑ Guarantor ❑ Self **Check here if information is same as patient ❑**

Responsible Party Name (Last): ______ (First): ______ ❑ F - Female ❑ M - Male

Guarantor Account Number: ______ Date of Birth: MM______ /DD______ /YYYY______

Social Security Number: ______ - ______ - ______ Telephone: ______

Responsible Party's Email Address: ______ Sex: ❑ F - Female ❑ M - Male

Address: ______ City: ______ State: ______ Zip Code: ______

Employer: ______ Employer Phone Number: ______

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number: ______ (______) ______

Name of Insured: ______ Patient Relationship to Insured: ______

Subscriber ID (Policy Number): ______ Group ID: ______ Co-Pay Amount: ______

Effective Date: ______ Termination Date: ______ Date of Birth: MM______ /DD______ /YYYY______

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number: ______ (______) ______

Name of Insured: ______ Patient Relationship to Insured: ______

Subscriber ID (Policy Number): ______ Group ID: ______ Co-Pay Amount: ______

Effective Date: ______ Termination Date: ______ Date of Birth: MM______ /DD______ /YYYY______

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge:

Patient (or Responsible Party) Signature: ______ ***Date:*** ______

Coliseum Heart, Lung & Vascular Surgery

General Consent for Care and Treatment

TO THE PATIENT: You have the rights, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intent that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

Patient Name: ______________________________

Date of Birth: ______________________________

PHARMACY INFO:

Primary Pharmacy: ______________________________

Address: ______________________________

Phone Number: ______________________________

Alternate Pharmacy: ______________________________

Address: ______________________________

Phone Number: ______________________________

ADVANCED DIRECTIVES:

❑ Do Not Resuscitate ❑ Durable Power of Attorney ❑ Health Care Power of Attorney
❑ Full Code ❑ Living Will ❑ NONE
❑ Other: ______________________________

PRIMARY CARE PROVIDER:

Name: ______________________________

Phone: ______________________________

Address/City: ______________________________

REFERRING PROVIDER:

Who referred you to us? ______________________________

If a group practice, what is Provider's Name? ______________________________

Phone Number: ______________________________

Address/City: ______________________________

EMAIL ADDRESS: ______________________________

Thank you!

Patient Name: ______________________

Patient Date of Birth: ______________________

SOCIAL HISTORY

Do you smoke? ❑ Yes ❑ No
How often?/Packs per day: ______________________
Are you a former smoker? ❑ Yes ❑ No
If Yes, when did you quit? ______________________
Do you drink alcohol regularly? ❑ Yes ❑ No
If Yes, how much? ______________ How Often? ______________
Do you drink caffeine? ❑ Yes ❑ No
If Yes, how much? ______________ How Often? ______________
Have you ever used illicit street drugs? ❑ Yes ❑ No
If Yes, what substance? ______________________
Are you currently using illicit street drugs? ❑ Yes ❑ No
If Yes, what substance? ______________________
How often do you exercise? ______________________
What type of exercise do you do? ______________________

MALES ONLY

Conditions	Past	Present
Loss of sexual function	______	______
Discharge from penis	______	______
Lump in testicles	______	______

Date of last prostate exam: ______________________
Was it normal? ❑ Yes ❑ No
Colonoscopy: ______________________

FEMALES ONLY

Conditions	Past	Present	Conditions	Past	Present
Abnormal pap smear	______	______	Nipple discharge	______	______
Breast lump	______	______	Painful intercourse	______	______
Bleeding between periods	______	______	Vaginal discharge	______	______
Extreme menstrual pain	______	______	Hot flashes	______	______

Date of last menstrual period: ______________________
Was it normal? ❑ Yes ❑ No

Date of last pap smear: ______________________
Was it normal? ❑ Yes ❑ No

Date of last mammogram: ______________________
Was it normal? ❑ Yes ❑ No

Colonoscopy: ______________________

Patient Name: ____________________

Patient Date of Birth: ____________________

MEDICAL HISTORY - Do you have or have you ever had any of the following conditions:

Condition	Yes	No
AIDS/HIV	❑ Yes	❑ No
Alcohol/Drug Problems	❑ Yes	❑ No
Anemia/Low Blood Counts	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Blood Clots	❑ Yes	❑ No
Cancer (Type: ____________________)	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No
Circulation Problems	❑ Yes	❑ No
COPD/Emphysema	❑ Yes	❑ No
Diabetes (Sugar)	❑ Yes	❑ No
Easy Bleeding	❑ Yes	❑ No
Eating Disorder (Anorexia/Bulimia)	❑ Yes	❑ No
Genital Herpes	❑ Yes	❑ No
Genital Infections (Chlamydia/Gonorrhea)	❑ Yes	❑ No
Genital Warts/HPV	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Gout	❑ Yes	❑ No
Hay Fever/Pollen Allergy	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
Hearing Loss	❑ Yes	❑ No
Heart Attack/Heart Disease	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Hemorrhoids	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No
Hernia	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No
Infertility (difficulty getting pregnant)	❑ Yes	❑ No
Kidney/Bladder Problems	❑ Yes	❑ No
Liver Disease/Jaundice/Hepatitis	❑ Yes	❑ No
Mental Trouble/Depression/Anxiety	❑ Yes	❑ No
Pneumonia	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Seizure/Fits/Epilepsy	❑ Yes	❑ No
Serious Injury/Serious Accident	❑ Yes	❑ No
Sickle Cell Anemia	❑ Yes	❑ No
Skin Disorders	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Thyroid Problem	❑ Yes	❑ No
Transfusion (Year: ______________)	❑ Yes	❑ No
Tuberculosis (TB)	❑ Yes	❑ No
Ulcers	❑ Yes	❑ No

Other: (Specify) ________________________________

Other: (Specify) ________________________________

HOSPITALIZATIONS AND SURGERIES

Have you even been hospitalized? ❑ Yes ❑ No

Have you even had surgery? ❑ Yes ❑ No

Year	Place (Hospital/Clinic/Medical Practice)	Reason for Hospitalization/Surgery

IMMUNIZATIONS

Date of last Influenza Vaccine: ________________________________

Date of last Pneumonia Vaccine: ________________________________

Others (please include date of each): ________________________________

Patient Name: ____________________

Patient Date of Birth: ____________________

FAMILY HISTORY - (list all family members)

Relative	Age	If Deceased, Age of Death	Medical Problems/Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings:			
Spouse			
Children:			

MEDICATIONS - Please list all medications you are currently taking (including over-the-counter and herbal medications)

Medication	Dosage	Frequency	Medication	Dosage	Frequency

ALLERGIES - List any medication and non-medication allergies/intolerances

Name	Type of Reaction

Are you allergic to: Seafood? ❑ Yes ❑ No Shell Fish? ❑ Yes ❑ No Iodine Dye: ❑ Yes ❑ No

Other Allergies: ____________________

Name: Date of Birth: Today's Date:

	PAST	PRESENT	SYMPTOM
GENERAL			
	☐	☐	Chills
	☐	☐	Fever
	☐	☐	Weight Loss
	☐	☐	Numbness
	☐	☐	Sweats
SKIN			
	☐	☐	Bruise Easily
	☐	☐	Hives
	☐	☐	Itching
	☐	☐	Change in Moles
	☐	☐	Rash
	☐	☐	Scars
	☐	☐	Sore than won't heal
EYE, EAR, NOSE THROAT			
	☐	☐	Bleeding Gums
	☐	☐	Crossed Eyes
	☐	☐	Difficulty Swallowing
	☐	☐	Double Vision
	☐	☐	Earache
	☐	☐	Ear Discharge
	☐	☐	Hoarseness
	☐	☐	Jaw Clicking
	☐	☐	Loss of Hearing
	☐	☐	Loss of Smell
	☐	☐	Nosebleeds
	☐	☐	Ringing in Ears
	☐	☐	Sinus Problems
	☐	☐	Loss of Vision
RESPIRATORY			
	☐	☐	Cough
	☐	☐	Shortness of Breath
	☐	☐	Snoring
	☐	☐	Lung Disease
	☐	☐	Cough up Sputum/Blood
CARDIOVASCULAR			
	☐	☐	Chest Pain
	☐	☐	Irregular Heart Beat
	☐	☐	Low Blood Pressure
	☐	☐	Poor Circulation
	☐	☐	Rapid Heart Beat
	☐	☐	Swelling in Ankles
	☐	☐	Heart Murmur
ENDOCRINE			
	☐	☐	Excessive Thirst
	☐	☐	Hair Loss
	☐	☐	Heat/Cold Intolerance
	☐	☐	Thyroid Problems
	☐	☐	Diabetes

	PAST	PRESENT	SYMPTOM
GASTROINTESTINAL			
	☐	☐	Abdominal Pain
	☐	☐	Poor Appetite
	☐	☐	Bloating
	☐	☐	Bowel Changes
	☐	☐	Constipation or Diarrhea
	☐	☐	Gas
	☐	☐	Heartburn or Indigestion
	☐	☐	Hemorrhoids
	☐	☐	Nausea or Vomiting
GENITO-URINARY			
	☐	☐	Frequent Urinating
	☐	☐	Lack of Bladder Control
	☐	☐	Painful Urination
	☐	☐	Blood in Urine
	☐	☐	Waking up at Night to Urinate
MUSCLE/JOINT/BONE Pain, Weakness, Numbness in:			
	☐	☐	Arms
	☐	☐	Back
	☐	☐	Feet
	☐	☐	Hands
	☐	☐	Hips
	☐	☐	Legs
	☐	☐	Neck
	☐	☐	Shoulders
	☐	☐	Cramping of Legs with Exercise
	☐	☐	Varicose Veins
NEUROLOGICAL			
	☐	☐	Dizziness/Lightheadedness
	☐	☐	Weakness
	☐	☐	Fainting
	☐	☐	Headache
	☐	☐	Difficulty Walking
	☐	☐	Memory Loss
	☐	☐	Numbness
	☐	☐	Visual Disturbances
PSYCHIATRIC			
	☐	☐	Depression
	☐	☐	Headache
	☐	☐	Loss of Sleep
	☐	☐	Nervousness
	☐	☐	Stress
	☐	☐	Trouble Concentrating
HEMATOLOGICAL			
	☐	☐	Anemia
	☐	☐	Bruising
	☐	☐	Bleeding Disorder
	☐	☐	Blood Clots
	☐	☐	Miscarriage

COLISEUM
HEART, LUNG & VASCULAR