Patient Information Sheet

Acct #: _____ **Date:** _____

Patient Information

Name: _____
Last Name First Name Middle Initial

Gender: _____ Date of Birth: _____ SSN: _____

Marital Status: _____ Employment Status: _____

Permanent/ Mailing Address

Street Address: _____

City, State, Zip: _____

Telephone (Home): _____ Telephone (Work): _____

Telephone (Cell): _____ E-mail: _____

Local Address

☐ Same as Permanent/Mailing Address

Street Address: _____

City, State, Zip: _____

Telephone (Home): _____ Telephone (Cell): _____

Emergency Contact

Name: _____
Last Name First Name Middle Initial

Telephone (Home): _____ Telephone (Work): _____

Relationship to Patient: _____

Patient's Other Care Providers

Who is your **Primary Care Physician?** **Who referred you** to Southwest EP Clinic?

_____ _____

Tel: _____ Tel: _____

Are you a resident of a(n): ☐ nursing home ☐ extended care facility ☐ skilled nursing facility ☐ assisted living facility?

Are you in enrolled in hospice care? ☐ Yes ☐ No

I certify that I have insurance coverage as listed below and assign to Southwest EP Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I allow Southwest EP Clinic to use my personal details and health care information and permit disclosure of same to my insurance companies and their agents and intermediaries for the sake of determining insurance benefits and obtaining payment for services. Any balance left unpaid for 90 days may be assigned to a collection agency and I will be responsible for all associated fees.

X _____ _____ _____

Signature **Date** **Relationship to patient (if representative)**

Acknowledgment of Privacy Practice

NOTICE AND ACKNOWLEDGMENT OF PRIVACY PRACTICE

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 third-party payers; and to
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received, been offered, or reviewed Southwest EP Clinic's 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 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that the clinic restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the clinic is not required to agree to my requested restrictions, but if the clinic does agree, it will be bound to abide by such restrictions.

X _____ _____

Signature Date

_____ _____

Patient Name Relationship to Patient
(If signature of Personal Representative)

If you would like to permit Southwest EP Clinic to communicate with any other person or people regarding your care, please list their name(s) below. At any time, you may add any person to this list or remove them from the list by submitting a request in writing.

Name: _____

Name: _____

Name: _____

Name: _____

Acknowledgement of Fee Schedule for Provider-Completed Forms

Southwest EP Clinic charges an administrative fee for certain work or insurance related documents presented by patients for completion by its providers. These documents include disability insurance benefit forms and Family and Medical Leave Act (FMLA) forms. Typically, your employer or insurance company will require these forms when seeking leave because a medical condition prevents you from reporting for work. A licensed medical professional must complete and sign these documents certifying that the medical information is correct.

We will be happy to assist you by completing the provider section(s) of these forms. The fee for this service is $50 per document for all new benefit claims and $25 per document for follow-up paperwork. Copies of medical records for a disability claim are provided to the disability company at no charge to the patient. These fees are due prior to the completion of the forms.

Our priority is providing treatment to our patients; therefore, we ask that you give us a minimum of ten (10) business days for completion of forms.

Please follow these steps to ensure the successful and timely completion of your forms:

1. Obtain a copy of the required forms from your employer or insurance company.
   Alternatively, you can request the appropriate FMLA form or a generic "Patient Short Term Disability Form" from us. The FMLA form is also available from the Wage and Hour Division of the U.S. Department of Labor:
   http://www.dol.gov/whd/forms/wh-380-e.pdf (for Employees)
   http://www.dol.gov/whd/forms/wh-380-f.pdf (for Family Members)
2. Complete all parts of the form that are to be completed by the employee.
3. Mail or drop off the form(s) at our main office.
   Remember to include a check payable to "Southwest EP Clinic".
   Our address is: **Southwest EP Clinic**
   2730 S. Val Vista Drive, Suite 158, Building 10
   Gilbert, AZ 85295
4. Please allow 10 business days for completion.
5. Please remember, the forms will be completed after we receive your payment.
   We encourage you to submit the forms as soon as possible.

I acknowledge that I have been advised of the above-stated fees.

X _____ _____

Signature Date

_____ _____

Patient Name Relationship to Patient
(If signature of Personal Representative)

Medicare Lifetime Authorization

Patient Name: _____

Medicare #: _____ Chart #: _____

Authorization Period: _____ To* _____

(OR UNTIL RESCINDED IF UNSPECIFIED)*

I hereby request and direct that payment of Medicare benefits be made on my behalf to Southwest EP Clinic for any services furnished me during the effective period of this authorization. I understand I will be financially responsible for my yearly Medicare/Insurance deductible and co-insurance.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

Additionally, I authorize any holder of medical information about me, including Southwest EP Clinic, to release to the Department of Health and Human Services, its agents, its intermediaries, or its carriers any information needed to determine these benefits or the benefits payable for related services or a related Medicare Insurance claim.

I further permit a copy of this authorization to be used in place of the original.

X _____ _____

Patient/Representative Signature | Date

_____ _____

Printed Name | Relationship to Patient
(If signature of Personal Representative)

Patient History

Date: _____ Chart #: _____

Name: _____ DOB: _____ Age: _____

Occupation: _____ Retired: ☐ No ☐ Yes

Referring Doctor: _____

Reason for Visit: _____

Select yes or no for the following:

Past Medical History

☐Y☐N history of Diabetes Mellitus
☐Y☐N history of Hypertension
☐Y☐N history of Thyroid Disorders
☐Y☐N history of Coronary Artery Disease
☐Y☐N history of Prior MI
☐Y☐N history of Cath Stent Placement
☐Y☐N history of Congestive Heart Failure
☐Y☐N history of Cardiac Pacemaker
☐Y☐N history of Cardiac Defibrillator
☐Y☐N history of Catheter Ablation
☐Y☐N history of Atrial Fibrillation/Flutter

Social History

☐Y☐N Alcohol Use
☐Y☐N Smoking (if yes, frequency_____)
☐Y☐N Illicit Drug Use

Family History

☐Y☐N Heart Disease
☐Y☐N Hypertension
☐Y☐N Sudden Cardiac Death
☐Y☐N Wolf Parkinson White Syndrome

Review of Systems-Are you currently experiencing any of the following symptoms?

☐Y☐N Weight Change
☐Y☐N Chills
☐Y☐N Fever
☐Y☐N Night Sweats
☐Y☐N Headache
☐Y☐N Eyesight Problems
☐Y☐N Hearing Loss
☐Y☐N Ringing in the Ears
☐Y☐N Nosebleeds
☐Y☐N Lump in the Neck
☐Y☐N Breast Lump

☐Y☐N Chest Pain/Discomfort
☐Y☐N Palpitations
☐Y☐N Shortness of Breath
☐Y☐N Difficulty Swallowing
☐Y☐N Nausea
☐Y☐N Black or Bloody Stools
☐Y☐N Dysuria
☐Y☐N Rashes
☐Y☐N Libido Changes

☐Y☐N Muscle Aches
☐Y☐N Dizziness
☐Y☐N Vertigo
☐Y☐N Fainting (Syncope)
☐Y☐N Anxiety

Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Legally Separated ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes / ☐ No # of Sons: _____ # of Daughters: _____

Race:

☐ Caucasian ☐ African American ☐ Hispanic ☐ Native American
☐ Asian ☐ Pacific Islander ☐ Other: _____

2730 S. Val Vista Drive
Suite 158, Building 10
Gilbert, AZ 85295-1680
Tel: (480) 776-6844

Name: _____

Family History

Other major health problems in your family history:

Health problem(s): _____

Relation: _____ Age at death (if deceased): _____

Health problem(s): _____

Relation: _____ Age at death (if deceased): _____

Health problem(s): _____

Relation: _____ Age at death (if deceased): _____

Health problem(s): _____

Relation: _____ Age at death (if deceased): _____

Health problem(s): _____

Relation: _____ Age at death (if deceased): _____

Health problem(s): _____

Relation: _____ Age at death (if deceased): _____

Health problem(s): _____

Relation: _____ Age at death (if deceased): _____

Allergies

Are you allergic to any medications? ☐ Yes / ☐ No

Medication	**Reaction(s)**

Do you have any other allergies? (foods, adhesive tape, iodine, latex, etc.)

_____

_____

_____

_____

_____

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Tel: (480) 776-6844

Name: _____

Medications & Supplements

Current medications:

Medication	Dosage	How often?

Vitamins and Supplements:

Vitamin/Supplement	Dosage	How often?

PRINT

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