# 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 |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |
| | | |

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:

**GENERAL**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Chills |
| ❑ | ❑ | Fever |
| ❑ | ❑ | Weight Loss |
| ❑ | ❑ | Numbness |
| ❑ | ❑ | Sweats |

**SKIN**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Bruise Easily |
| ❑ | ❑ | Hives |
| ❑ | ❑ | Itching |
| ❑ | ❑ | Change in Moles |
| ❑ | ❑ | Rash |
| ❑ | ❑ | Scars |
| ❑ | ❑ | Sore than won't heal |

**EYE, EAR, NOSE THROAT**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | 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**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Cough |
| ❑ | ❑ | Shortness of Breath |
| ❑ | ❑ | Snoring |
| ❑ | ❑ | Lung Disease |
| ❑ | ❑ | Cough up Sputum/Blood |

**CARDIOVASCULAR**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Chest Pain |
| ❑ | ❑ | Irregular Heart Beat |
| ❑ | ❑ | Low Blood Pressure |
| ❑ | ❑ | Poor Circulation |
| ❑ | ❑ | Rapid Heart Beat |
| ❑ | ❑ | Swelling in Ankles |
| ❑ | ❑ | Heart Murmur |

**ENDOCRINE**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Excessive Thirst |
| ❑ | ❑ | Hair Loss |
| ❑ | ❑ | Heat/Cold Intolerance |
| ❑ | ❑ | Thyroid Problems |
| ❑ | ❑ | Diabetes |

**GASTROINTESTINAL**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Abdominal Pain |
| ❑ | ❑ | Poor Appetite |
| ❑ | ❑ | Bloating |
| ❑ | ❑ | Bowel Changes |
| ❑ | ❑ | Constipation or Diarrhea |
| ❑ | ❑ | Gas |
| ❑ | ❑ | Heartburn or Indigestion |
| ❑ | ❑ | Hemorrhoids |
| ❑ | ❑ | Nausea or Vomiting |

**GENITO-URINARY**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Frequent Urinating |
| ❑ | ❑ | Lack of Bladder Control |
| ❑ | ❑ | Painful Urination |
| ❑ | ❑ | Blood in Urine |
| ❑ | ❑ | Waking up at Night to Urinate |

**MUSCLE/JOINT/BONE**

Pain, Weakness, Numbness in:

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Arms |
| ❑ | ❑ | Back |
| ❑ | ❑ | Feet |
| ❑ | ❑ | Hands |
| ❑ | ❑ | Hips |
| ❑ | ❑ | Legs |
| ❑ | ❑ | Neck |
| ❑ | ❑ | Shoulders |
| ❑ | ❑ | Cramping of Legs with Exercise |
| ❑ | ❑ | Varicose Veins |

**NEUROLOGICAL**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Dizziness/Lightheadedness |
| ❑ | ❑ | Weakness |
| ❑ | ❑ | Fainting |
| ❑ | ❑ | Headache |
| ❑ | ❑ | Difficulty Walking |
| ❑ | ❑ | Memory Loss |
| ❑ | ❑ | Numbness |
| ❑ | ❑ | Visual Disturbances |

**PSYCHIATRIC**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Depression |
| ❑ | ❑ | Headache |
| ❑ | ❑ | Loss of Sleep |
| ❑ | ❑ | Nervousness |
| ❑ | ❑ | Stress |
| ❑ | ❑ | Trouble Concentrating |

**HEMATOLOGICAL**

| PAST | PRESENT | SYMPTOM |
|---|---|---|
| ❑ | ❑ | Anemia |
| ❑ | ❑ | Bruising |
| ❑ | ❑ | Bleeding Disorder |
| ❑ | ❑ | Blood Clots |
| ❑ | ❑ | Miscarriage |