Jerome V. Dwyer, MD, MBA

Bryon L. Beck, PA-C

3009 N. Ballas Road
Building B, Suite 202
St. Louis, MO 63131

Phone: 314-995-6839
Fax: 314-995-6883

Patient Intake Form

Patient Name:	*Last*	*First*	*MI*
Gender: ☐ M ☐ F	**Date of Birth:** / /	**SSN:**	
Address:	*Street*	*City*	*State* / *Zip*
Telephone Number:	*Home* ( )	*Mobile* ( )	
E-mail Address:			
Marital Status:	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐Separated		
Ethnicity:	☐ Non-Hispanic ☐ Hispanic or Latin ☐ Refuse to report		
Race:	☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race ☐ Refuse to report		
Preferred Language:	☐ English ☐ Spanish ☐ Indian (Hindi and Tamil) ☐ Russian ☐ Other		
Emergency Contact:	*Name*	*Telephone Number* ( )	*Relationship to You*
Primary Physician/ Referring Provider:	*Name*	*Telephone Number* ( )	
Primary Pharmacy:	*Name*	*Telephone Number* ( )	
Primary Insurance Information:	*Name of Insurance Company*		
	Name of Policy Holder	*Policy Holder's Date of Birth* / /	*Relationship to You*
Secondary Insurance Information:	*Name of Insurance Company*		
	Name of Policy Holder	*Policy Holder's Date of Birth* / /	*Relationship to You*

Your signature affirms that the information given above, to the best of your knowledge, is accurate as of the date of signing.

______________________________ Patient Signature

____ / ____ / ____ Date

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Statement of Financial Responsibility

Read and understand this document thoroughly. The Statement of Financial Responsibility is to be completed and signed with your full knowledge that you will be held solely financially liable if:

1) All conditions and guidelines set forth by your insurance carrier are not met.
2) You are covered by a plan with whom our medical providers are not contracted.
3) You are uninsured.
4) You fail to provide valid insurance information with the timely filing guidelines set forth by your insurance plan.
5) You receive services that are not covered by your insurance plan.

- If you are a participant with an insurance plan (HMO, PPO, or commercial) with whom our medical providers are not contracted as a participating provider, you will be held responsible for payment in full for any and all non-covered services.
- If you are a participant with an insurance plan with whom our medical providers are a participating provider, you will be held responsible for any non-covered services provided.
- If a referral is required by your insurance carrier and is not valid, you are responsible for the complete charged balance on your account.
- If you are not covered by any insurance plan, you will be held financially responsible for any and all services you receive. Payment will be due and expected at the time of service.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my medical provider to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand that I am financially responsible for all charges and collections costs incurred. I further acknowledge that any insurance benefits, when received by and paid to St. Louis Cardiology Center, PC will be credited to my account in accordance with the above said assignment.

____
Insurance Plan (N/A if uninsured)

______________________________   ____/____/____
Patient Name (Print)   Date of Birth

______________________________   ____/____/____
Patient Signature   Date

______________________________   ____/____/____
Witness Signature   Date

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:	*Last*		*First*		*MI*
Gender:	☐ M ☐ F	**Date of Birth:**	/ /	**SSN:**	
Address:	*Street*	*City*	*State*	*Zip*	

The following specific person/facility is authorized to use or disclose health information about me:

Name of Healthcare Provider/Facility/Entity				
Address:	*Street*	*City*	*State*	*Zip*
Contact Numbers:	*Phone* ( )	*Fax* ( )		

The following specific person/facility is authorized to receive health information about me:

St. Louis Cardiology Center, PC
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Information to be Released:	☐ Complete medical record ☐ Most recent hospital records ☐ Laboratory reports ☐ Surgical reports ☐ EKG, Echocardiogram, Stress test ☐ Cardiac catheterization ☐ Other (specify):
Purpose/Use of Disclosure:	☐ Further medical care ☐ Insurance eligibility/benefits ☐ Legal investigation or action ☐ Changing medical provider ☐ Personal use ☐ Other (specify):

If you do not wish for information regarding alcohol/substance abuse, HIV/AIDS, or mental health to be disclosed, please indicate below. Otherwise, this information may be disclosed as part of your medical record.

☐ Do not disclose my information regarding alcohol/substance abuse, HIV/AIDS, or mental health.

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying the disclosing entity listed above, in writing, of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I have had the opportunity to review and understand the content of this authorization form. By signing, I confirm that this form accurately reflects my wishes.

Unless otherwise indicated, this authorization expires one year from the date of signing ____/____/____
Expiration Date

______________________________ ____/____/____
Patient Signature/Legal Representative Date

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Acknowledgement of Receipt of Privacy Notice

By completing this form, you acknowledge that St. Louis Cardiology Center, PC has provided for your review a copy of its Privacy Notice. The Privacy Notice explains how your health information will be handled in various situations. In addition, you are providing a list of individuals to whom you authorize the release of your information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that you sign this form on your first date of service. If your first date of service was due to an emergency, we are required to give you this notice and to obtain your signature acknowledging the receipt of this notice as soon as possible after the emergency.

Please complete the information below for those to whom you authorize St. Louis Cardiology Center, PC to release your medical information:

Name	Telephone Number	Relationship to You

Please acknowledge the following and sign:

☐ I have reviewed the St. Louis Cardiology Center, PC Privacy Notice.

☐ St. Louis Cardiology Center, PC has given me the opportunity to discuss my concerns and questions about the privacy of my health information.

______________________ ______________________ ____/____/____

Patient Signature | Printed Name | Date

ST. LOUIS CARDIOLOGY CENTER, PC STAFF USE ONLY

If the Acknowledgement of Receipt of Privacy Notice is not completed:

1. Was a copy of the Privacy Notice provided to the patient for review? ☐ Yes ☐ No
2. Explain why the patient was unable, or refused to sign the acknowledgement form and the efforts made in trying to obtain the patient's signature:

____

____

____

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NEW PATIENT MEDICAL HISTORY

Patient Name:	*Last*	*First*	*MI*

Current Medications:	Medication Name	Dose (e.g. 10mg)	Frequency (e.g. twice daily)

Allergies:	Drug/Substance	Reaction

Past/Chronic Medical Conditions:	

Surgical History:	Procedure/Operation	Date

Social Habits History:	
	☐ Non-smoker (no history of significant smoking) ☐ Former smoker → How much did you smoke? __________ packs per day. How long did you smoke? __________ Year quit: __________ ☐ Current smoker → How much do you smoke? __________ packs per day. How long have you smoked? _________ years. ☐ Chew tobacco → How much do you chew? __________ cans per day. How long have you chewed? _________ years.
	Do you drink? ☐ Soda __________ oz per day ☐ Coffee __________ cups per day ☐ Tea ___________ oz per day ☐ Alcohol → Type: _________________________ Frequency: ____________________ ☐ History of alcohol abuse → When did you stop drinking? __________
	Do you currently use or have a history of illicit drug use? ☐ Yes ☐ No If yes, please specify: ____
	Do you perform any routine exercise? ☐ Yes ☐ No If yes, please specify: ____

ST. LOUIS CARDIOLOGY CENTER, PC

Family History:			
	Father	☐ Alive Age: ______ ☐ Deceased Age: ______ Cause of death?_____________	☐ No significant medical problems ☐ High blood pressure ☐ Diabetes ☐ Stroke ☐ Heart attack/bypass surgery/stents ☐ Congestive heart failure ☐ Cancer (specify: ______________________) ☐ Other (specify: _______________________)
	Mother	☐ Alive Age: ______ ☐ Deceased Age: ______ Cause of death?_____________	☐ No significant medical problems ☐ High blood pressure ☐ Diabetes ☐ Stroke ☐ Heart attack/bypass surgery/stents ☐ Congestive heart failure ☐ Cancer (specify: ______________________) ☐ Other (specify: _______________________)
	Siblings	☐ Alive Age: ______ ☐ Deceased Age: ______ Cause of death?_____________	☐ No significant medical problems ☐ High blood pressure ☐ Diabetes ☐ Stroke ☐ Heart attack/bypass surgery/stents ☐ Congestive heart failure ☐ Cancer (specify: ______________________) ☐ Other (specify: _______________________)
	Paternal Grandparents	☐ Alive Age: ______ ☐ Deceased Age: ______ Cause of death?_____________	☐ No significant medical problems ☐ High blood pressure ☐ Diabetes ☐ Stroke ☐ Heart attack/bypass surgery/stents ☐ Congestive heart failure ☐ Cancer (specify: ______________________) ☐ Other (specify: _______________________)
	Maternal Grandparents	☐ Alive Age: ______ Deceased Age: ______ Cause of death?_____________	☐ No significant medical problems ☐ High blood pressure ☐ Diabetes ☐ Stroke ☐ Heart attack/bypass surgery/stents ☐ Congestive heart failure ☐ Cancer (specify: ______________________) ☐ Other (specify: _______________________)

Review of Systems:	☐ Fatigue ☐ Fever/chills ☐ Weakness ☐ Weight loss ☐ Weight gain ☐ Loss of appetite ☐ Night sweats
	☐ Chest pain/pressure ☐ Shortness of breath with exertion ☐ Palpitations ☐ Passing out ☐ Dizziness/lightheadedness ☐ Swelling ☐ Heart murmur ☐ Irregular heartbeat ☐ Leg/calf pain when walking ☐ Varicose veins
	☐ Coughing ☐ Chest congestion ☐ Shortness of breath ☐ Wheezing ☐ Coughing up blood ☐ History of pneumonia ☐ Sleep apnea
	☐ Diabetes ☐ Thyroid abnormalities ☐ Excessive sweating ☐ Excessive thirst ☐ Heat/cold intolerance
	☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Heartburn/Acid reflux ☐ Difficulty swallowing ☐ Constipation ☐ Diarrhea ☐ Bloody stools ☐ History of ulcers ☐ Gallstones ☐ Hepatitis
	☐ Anemia ☐ Bleeding or clotting disorders ☐ Bruise easily ☐ History of blood clots/DVT
	☐ Joint pain/stiffness ☐ Reduce range of motion ☐ Arthritis ☐ Muscle aches ☐ Leg cramps ☐ Gout
	☐ Loss of sensation ☐ Numbness/tingling ☐ Stroke ☐ TIA ☐ Seizure ☐ Fainting/Pass out ☐ Persistent headaches ☐ Balance/stability problems ☐ Memory loss
	☐ Anxiety ☐ Depression ☐ Mood changes ☐ Suicidal thoughts ☐ Sleep disturbances
	☐ Diminished vision ☐ Blurred vision ☐ Cataracts ☐ Glaucoma ☐ Macular degeneration
	☐ Difficult/painful urination ☐ Blood in urine ☐ Frequent UTI's ☐ Chronic kidney disease ☐ Kidney stones ☐ Urinary incontinence
	☐ Rashes ☐ Abnormal hair growth ☐ Open sores ☐ Skin cancer ☐ Hearing loss ☐ Nosebleeds ☐ Ringing in ears ☐ Sinus infections ☐ Earaches ☐ Dental problems ☐ Change in voice