ST. LOUIS CARDIOLOGY CENTER, P.C.

Patient:_____ Home Phone:( )_____
(Last) (First) (MI) Cell Phone: ( )_____

Address:_____
(Street Address) (City) (State) (Zip)

E-Mail Address: _____

Sex: ❑ F ❑ M Age:_____ Birthdate:___/___/___ Social Security :_____

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

Patient's Employer:_____
Business Address:_____
Occupation:_____ Business Phone: ( )_____
Spouse:_____ Birthdate:___/___/___ SS Number:_____
Spouse's Employer:_____
Occupation:_____ Business Phone: ( )_____

INSURANCE INFORMATION

Name of **Primary** Insurance Co:._____Primary Carrier:_____
Relationship:_____
ID #:_____ GroupNumber:_____ Copay:_____
Insured Birthdate:____/____/_____ Policy Effective Date:____/____/_____

Name of **Secondary** Insurance Co:_____Primary Carrier:_____
Relationship:_____
ID #:_____ Group Number:_____
Insured Birthdate:____/____/_____ Policy Effective Date:____/____/_____

In case of emergency, who should be notified? (This should be someone who DOES NOT reside with you)

Name: _____ Relationship:_____ Phone ( )_____
Pharmacy:_____ Phone: ( )_____
Primary/Referring Physician:_____

Ethnicity: ❑ Not Hispanic or Latin ❑ Hispanic or Latin ❑ Refuse to Report

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander
❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race ❑ Refuse to Report

Preferred Language: ❑ English ❑ Other ❑ Indian (includes Hindi and Tamil)❑ Spanish ❑ Russian

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. **If a referral is required with my insurance company and is not valid, I am responsible for the complete charged balance on my account.** I further expressly agree and acknowledge that my signature on this document authorizes my physician 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 collection costs incurred. I further acknowledge that any insurance benefits, when received by and paid to *St. Louis Cardiology Center, P.C.*, will be credited to my account in accordance with the above said assignment.

Date:_____ _____
Authorized Signature of Subscriber

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

STREET ADDRESS _____ CITY, SATE, ZIP _____ (___)___ Patient Telephone Number

I HEREBY AUTHORIZE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

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

NAME OF HEALTH CARE PROVIDER/PLAN/OTHER _____ STREET ADDRESS _____

Phone Number _____ Fax Number _____ CITY/STATE/ZIP CODE _____

The following person/facility is authorized to receive disclosure of protected health information about me:

NAME OF HEALTH CARE PROVIDER/PLAN/OTHER _____ STREET ADDRESS _____

Phone Number _____ Fax Number _____ CITY/STATE/ZIP CODE _____

INFORMATION TO BE RELEASED:

____ CURRENT MEDICAL HISTORY
____ HOSPITAL RECORDS INCLUDING REPORTS
____ LABORATORY REPORTS
____ OTHER (SPECIFY) _____
____ SURGICAL REPORTS
____ EKG, ECHO, STRESS TEST
____ CARDIAC CATHERIZATIONS
____ ENTIRE RECORD

PURPOSE/USE OF DISCLOSURE: (CHECK APPLICABLE CATEGORIES)

___ FURTHER MEDICAL CARE
___ INSURANCE ELIGIBILITY/BENEFITS
___ OTHER_____
___ LEGAL INVESTIGATION OR ACTION
___ CHANGING PHYSICIANS
___ PERSONAL

UNLESS YOU SIGN HERE, INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH MAY BE DISCLOSED:
NO, DO NOT DISCLOSE THIS INFORMATION _____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying_____ 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.

EXPIRATION DATE: This authorization expires on ____/____/____ or one year from date.

I HAVE HAD AN OPPORTUNITY TO REVIEW AND UNDERSTAND THE CONTENT OF THIS AUTHORIZATION FORM. BY SIGNING THIS AUTHORIZATION, I AM CONFIRMING THAT IT ACCURATELY REFLECTS MY WISHES.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** ____/____/____
(IF SIGNED BY OTHER THAN PATIENT, STATE RELATIONSHIP AND AUTHORITY TO DO SO)

WITNESS: _____

ST. LOUIS CARDIOLOGY CENTER, P.C.

Jerome V. Dwyer, MD
Bryon L. Beck, PA-C

ICAEL

ST. LOUIS CARDIOLOGY CENTER, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By completing this form, you acknowledge that St. Louis Cardiology Center, P.C. has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. In addition, you are providing a list of people to whom you authorize release of your information. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) 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, P.C. to release your medical information.

✓	Relationship	Name	Telephone Number
	Spouse		
	Daughter/Son		
	Other		
	None		

Check all that are true:

( ) I have received the St. Louis Cardiology Center, P.C. Privacy Notice.
( ) St. Louis Cardiology Center, P.C. has given me the chance to discuss my concerns and questions about the privacy of my health information.

Patient Signature Printed Name Date

St. Louis Cardiology Center, P.C. staff must complete if the Acknowledgement of Receipt of Privacy Notice is not completed:

1. Was patient given a copy of the Privacy Notice? YES NO

2. Explain why the patient was unable to or refused to sign acknowledgment form and efforts made in trying to obtain the patient's signature:

_____

_____

_____

St. Louis Cardiology Center, P.C.
3009 N. Ballas Road, Building B, Suite 202
St. Louis, Missouri 63131
Office: (314)995-6839 Fax: (314)995-6883

St. Louis Cardiology Center, P.C.

Patient Name_____

HOSPITAL ADMISSIONS		REASON FOR VISIT	
YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICATIONS _____

_____

DRUG ALLERGIES _____

_____

Mark (C) for current problems. Check (✓) box and indicate age when you had any of the following symptoms or diseases.

[ ] Shortness of breath
[ ] On exertion
[ ] Lying flat
[ ] Chest pain/Tightness
[ ] Leg pain when walking
[ ] Heart attack/Stoke
[ ] Tuberculosis
[ ] Coffee/Tea cups/day

[ ] High blood pressure
[ ] Rheumatic Fever
[ ] Heart murmur
[ ] Irregular pulse
[ ] Swollen ankles
[ ] Kidney disease
[ ] Anemia
[ ] Smoking packs/day

[ ] Numbness/Tingling
[ ] Dizzy/Faint Spells
[ ] Palpitations
[ ] Thyroid disease
[ ] Varicose veins
[ ] Vomiting
[ ] Diabetes
[ ] Alcohol (oz) week

Family History	Father	Mother	Brother	Brother	Sister	Sister	Mother's Relatives	Father's Relatives
Alive and Well								
Deceased								
High Blood Pressure								
Heart Disease								
Diabetes								
Kidney Disease								
Stroke								
Other								