PHOENIX CARDIAC SURGERY, P.C.

NAME: LAST: FIRST: MI:

ADDRESS:

CITY: STATE: ZIP:

PHONE: HOME: WORK:

CELL: PREFERRED CONTACT: HOME WORK CELL

SS#: DOB: AGE:

SEX: MALE FEMALE MARITAL STATUS: S M W D OTHER

RACE: WHITE BLACK/AFRICAN AMERICAN AMERICAN INDIAN/ALASKA NATIVE ASIAN
NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER OTHER DECLINED/NOT REPORTED

ETHNICITY: HISPANIC/LATINO NON HISPANIC/LATINO DECLINED/NOT REPORTED

PREFERRED LANGUAGE (if other than ENGLISH):

EMPLOYER: OCCUPATION:

EMERGENCY CONTACT: PHONE:

RELATION TO PATIENT:

PRIMARY INSURANCE: POLICY#:

GROUP #: NAME OF INSURED: DOB:

SECONDARY INSURANCE: POLICY#:

GROUP #: NAME OF INSURED: DOB:

REASON FOR YOUR VISIT:

ALLERGIES TO FOOD OR MEDICATION:

IF YES - WHAT REACTION(S) OCCUR:

PRIMARY CARE DOCTOR: PHONE:

ADDRESS:

CITY: STATE: ZIP:

REFERRING DOCTOR: PHONE:

ADDRESS:

CITY: STATE: ZIP:

I request that payment under the medical insurance program be made to Phoenix Cardiac Surgery, PC on any bills for services furnished to me by Phoenix Cardiac Surgery, PC. I authorize Phoenix Cardiac Surgery, PC to release to the Social Security Administration, its intermediaries or carriers, any information needed for this claim or related medical claims. I further permit a copy of this authorization to be used in place of the original. This authorization is further to apply to all private insurance claims for my illness.

PATIENT SIGNATURE: DATE:

PHOENIX CARDIAC SURGERY

Date___/___/____
Name: _____ SS#:_____-_____-_____
Date of Birth:___/___/_____ Age_____
Occupation:_____

Reason for consultation:

Past Medical History: (please circle conditions that pertain to you.)

Heart attack/Heart disease Diabetes High blood pressure
High cholesterol Stroke Emphysema Asthma Pneumonia
Tuberculosis Valley Fever Peripheral vascular disease Varicose veins
Thyroid disease Lung disease Hepatitis Cirrhosis/Liver disease
Kidney disease Cancer

Other: _____
_____
_____
_____

Past Surgeries:

Type	Date	Where

Allergies to medications? Y N Which ones?
1._____
2._____
3._____

Do you smoke? Y N **Did you ever smoke in the past?** Y N
When did you stop smoking? _____
How many packs per day? _____
How long have you been smoking? _____

Do you drink alcohol? Y N **Did you drink in the past?** Y N
When did you stop drinking? _____
How much? _____
Have you ever had alcohol withdraw from not drinking? Y N

Any history of recreational drug use? Y N
What type of drugs? _____
I.V. drugs? Y N

Any family history of medical problems? Y N if yes, please list:
1. _____
2. _____
3. _____
4. _____

Review of Systems:

Have you experienced any of the following symptoms?
(please circle the ones that apply to you)

General: recent weight gain/loss decrease appetite
unusual fatigue

Neuro: fainting vision problems numbness/tingling
slurred speech dizziness headaches/migraines

Cardiac: chest pain chest pressure palpitations

Pulm: shortness of breath difficulty breathing lying down
cough coughing up blood wheezing

GU: difficulty urinating burning/pain with urination
blood in urine discharge from penis/vagina

GI: constipation diarrhea blood in stool heartburn
nausea/vomiting

MS: joint pain muscle pain weakness in arms or legs

Reviewed by: _____ date: ____/____/____

Phoenix Cardiac Surgery, PC
H. Kenith Fang, MD Mark Tasset, MD Orazio Amabile, MD Modesto Colón, MD

MEDICATION LIST

Date:_____

Patient Name: _____

It is important we keep an up to date medication list on file for ALL of our patients. Please list all CURRENT medications (Name & Strength)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15: _____

PHOENIX CARDIAC SURGERY, P.C.

RELEASE OF MEDICAL RECORDS

I _____ authorize the release of medical records to Phoenix Cardiac Surgery, PC.

OFFICE USE ONLY

Comments: _____

_____

_____

_____

____ Please fax my records to **(602) 251-3126**

____ Please send my records to the following address:

3131 E. Clarendon Ave
Suite 102
Phoenix, AZ 85016

Patient Signature: _____

Patient Name: _____

Date of Birth: _____

Social Security #: _____

Thank you.

Phoenix Cardiac Surgery, PC

PHOENIX CARDIAC SURGERY, P.C.

PHARMACY INFORMATION

Please give as much information as you can about your preferred pharmacy below

Patient Name: _____

Pharmacy Name: _____

Address or Major Cross Streets: _____

City: _____ Zip: _____

Phone Number: _____

Please list secondary pharmacy below if you wish.

Pharmacy Name: _____

Address or Major Cross Streets: _____

City: _____ Zip: _____

Phone Number: _____

3131 E. Clarendon Avenue, #102 • Phoenix, AZ 85016 • (602) 253-9168 • (602) 251-3126 fax

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Phoenix Cardiac Surgery, P.C., an Arizona professional corporation (a/k/a "Yavapai Cardiac Surgery"), which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgement.

Date: _____

_____
Signature of Patient or Patient's Representative

_____
Print Name of Patient or Patient's Representative

FOR OFFICIAL USE ONLY

I, _____, made a good faith effort to obtain written acknowledgement of _____'s receipt of the Notice of Privacy Practices of Phoenix Cardiac Surgery, P.C., an Arizona professional corporation (a/k/a "Yavapai Cardiac Surgery"). However, I could not obtain written acknowledgement because: (please check the appropriate box)

- ❑ Individual refused to sign this Acknowledgement
- ❑ Communications barrier prohibited obtaining written acknowledgement
- ❑ An emergency situation prevented obtaining written acknowledgement
- ❑ Other (please specify)

_____

_____

_____