THE HEART INSTITUTE®

New York's Center for Minimally Invasive Cardiac Surgery

BypassTheOrdinary.com®

Cardiothoracic Surgery

501 Seaview Ave, Suite 202
Staten Island, New York 10305

Date__________________

Name______________________________________ Sex______________ DOB_________________ Age__________

Soc Sec #__________________________ Phone #______________________ Cell #________________________

Address ____

City____ State_____________Zip _____________

Guarantor Name (If under 18 or different than patient) ____

Patient Employed by_______________________________________ Business Phone #______________________

Primary Physician_________________ Referring Physician________________ Phone #______________________

Pharmacy Name and Location_______________________________________ Phone #______________________

In case of Emergency who should be notified?___________________________ Phone #______________________

Is this claim a result of an auto accident? Yes No Accident date______________________

Is this claim a result of a work-related accident? Yes No Accident date______________________

IMPORTANT!! Please complete the section below for each insurance claim you have. Please have your insurance card ready for us to copy. We also need referrals and any authorizations applicable.

Primary Insurance

Insurance Company___________________________ Policy Holder_______________________________________

Policy ID# __________________________________ Group____

Insurance Address____

Patient Relationship to Subscriber____________________________ Subscriber's Date of Birth_________________

Does your insurance require a referral/authorization for office visits? Yes No

Secondary Insurance

Insurance Company___________________________ Policy Holder_______________________________________

Policy ID# __________________________________ Group____

Insurance Address____

Patient Relationship to Subscriber____________________________ Subscriber's Date of Birth_________________

Release

I authorize the release of any medical records, lab results, x-rays, etc. to this office needed in my treatment and care. I authorize the release of any information necessary to expedite insurance claims, and request direct payment of benefits to the above provider. I understand that I am responsible for all deductibles, co-pays and cost shares as determined by my insurance coverage.

Patient, Parent or Guardian's signature____ Date____________________

I authorize my holder of medical or other information about me to release to the Social Security Administration and Health Care Financial Administration or its intermediaries or carrier any information needed for this or a related Medical claim. I permit a copy of this authorization to be used in place of the original, request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply.

Patient, Parent or Guardian's signature____ Date____________________

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Patient Health History

Name______________________________ **DOB**______________ **Date**____________

Age________ Sex___________ Height________ Weight__________

Chief Complaint____

History of Patient Illness: Date it started / location / duration / better or worse

____

____

____

____

Medical History: do you now or have you ever had any of the problems listed below, if so please check

Cardiac

___ *Hypertension*
___ *Coronary Artery Disease*
___ *Peripheral Vascular Disease*
___ *High Cholesterol*
___ *Heart Attack*
___ *Congestive Heart Failure*
___ *Murmur*
___ *Arrythmia*
___ *Angina / chest pain*
___ *Pericarditis*

Liver

___ *Jaundice*
___ *Cirrosis*
___ *Hepatitis*

Pulmonary

___ *Asthma / wheezing*
___ *COPD / Emphysema*
___ *Pneumonia*
___ *Bronchitis*
___ *Shortness of breath*
___ *Sleep apnea*
___ *Tuberculosis*
___ *Pulmonary Embolism*

Neurological

___ *Stroke / TIA*
___ *Seizures*
___ *Headaches*
___ *Loss of consciousness*

Gastrointestinal

___ *Peptic Ulcer*
___ *GERD / Heart Burn*
___ *Hiatal Hernia*
___ *Gall Stones*

Urologic

___ *BPH (enlarged prostate)*
___ *Urinary tract infection*
___ *Kidney failure*
___ *Dialysis*
___ *Kidney stones*
___ *STDs*

Endocrine

___ *Diabetes*
___ *Thyroid disease*

Other

___ *Anemia*
___ *Glaucoma*
___ *HIV*
___ *Alcohol addition*
___ *Drug addition*
___ *Anxiety disorder*
___ *Blood transfusion*
___ *Arthritis*
___ *Cancer*
___ *Depression*

Vascular

___ *Bleeding disorders*
___ *Vein stripping*
___ *Varicose veins*
___ *DVT*

Surgical History: Include procedure, date, surgeon and where procedure was performed

1. ____
2. ____
3. ____
4. ____

Hospitalizations: Please list separately the number of times, dates and reasons you may have been hospitalized

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Family History: Please check all that apply.

___ *Diabetes*	___ *Tuberculosis*	___ *Cancer*	___ *Stroke*
___ *Kidney Disease*	___ *Anemia*	___ *Asthma*	___ *High Blood Pressure*
___ *Gout/Arthritis*	___ *Migraines*	___ *Anxiety Disorder*	___ *Bleeding Disorders*
___ *COPD*	___ *Heart Disease*	___ *Deafness*	___ *Other*

Social History:

Occupation ____________ Race/Nationality__________ Primary Language__________ Marital Status: S M D W

Alcohol Usage: ___ Yes ___ No, if yes: ___ Socially ___ Daily ___ Rarely: amount ________________

Smoking History: ___ Yes ___ No, if yes: ___ currently / ____ year quit, # of years smoked_____, # pack/day______

Allergies / Reactions:

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

Current Medications:

Name	Dose	How often	Name	Dose	How often

Review of Systems: check any recent symptoms and explain below

General

___ *Fever*
___ *Chills*
___ *Night Sweats*

Cardio-Vascular

___ *Angia (exertional, rest)*
___ *Claudication*
___ *Dyspnea on exertion*
___ *Dizziness / Syncope*
___ *Edema*
___ *Fatigue*
___ *Palpitations*
___ *Paroxysmal Nocturnal Dyspnea*

Skin

___ *Infections*
___ *Rash*

Mouth

___ *Dysphagia*
___ *Hoarseness*
___ *Sore throat*
___ *Dentures*

Thorax & Pulmonary

___ *Chronic Cough*
___ *Hemoptysis*
___ *Sputum*
___ *Wheezing*

Gastrointestinal

___ *Constipation*
___ *Diarrhea*
___ *Indigestion*
___ *Melena*
___ *Nausea / Vomiting*
___ *Weight Change*

Eyes

___ *Double Vision*
___ *Blurred Vision*

Neck

___ *Pain*
___ *Stiffness*

Head

___ *Colds*
___ *Trauma*
___ *Migraines*

Genito-Urinary

___ *Discharge*
___ *Dysuria*
___ *Frequency*
___ *Hematuria*
___ *Incontinence*
___ *Nocturia*
___ *Pyuria*
___ *Urgency*

Explanation and Comments

____

____

____

Reviewer ____________________ Physician Signature ____________________