Cardiovascular and Thoracic Surgery
Washington Regional

Dear valued patient,

We are located at 3276 N. North Hills Blvd, Fayetteville, AR 72703 (Across from Washington Regional Medical Center (green-roofed buildings) in the same parking lot as Highlands Oncology).

We have enclosed our paperwork so you can fill this out completely in the comfort of your home with your records and medications readily available. PLEASE DO NOT MAIL THESE FORMS TO OUR OFFICE.

Upon arrival, please give the receptionist the following:

* Your completed paperwork (if enclosed)
* A list of current medications (or bring your medication bottles for nurse review)
* Driver's License or Picture ID
* Medical Insurance Cards
* Any co-pay, deductible, or amount not covered by insurance
* Any CDs or test results

New patient consultations are not assigned to one specific surgeon. If you have a specific doctor request, please notify our office in advance.

Patients who have a **post-operative or follow-up appointment** might see the Doctor of Nursing Practice (DNP) or Physician Assistant (PA).

Patients who are scheduled for **testing** such as an ultrasound will only see the Vascular Technician.

To keep your wait time to a minimum, please do not show up more than 10 minutes prior to your appointment. As a reminder, this is a surgery clinic which means there is a chance of an emergency. In such as case, we will do our best to see our patients in a timely fashion.

If you have any questions or need directions, please contact our office. We look forward to your visit.

Sincerely,
Management
Website: www.facebook.com/nwacardio

Cardiovascular and Thoracic Surgery
Washington Regional

3276 N. North Hills Blvd
Fayetteville, AR 72703
Office: 479-404-2110
Fax: 479-404-2111

PATIENT INFORMATION

NAME : _____

HOME PHONE # _____ **CELL #** _____

E-MAIL ADDRESS : _____

MAILING ADDRESS: _____

CITY & STATE: _____ **ZIPCODE:** _____

IF PO BOX **- STREET ADDRESS :** _____

_____ **MALE** _____ **FEMALE** **BIRTHDATE:** _____

SOCIAL SECURITY # : _____ **MARITAL STATUS :** _____

EMPLOYER NAME : _____ **PHONE # :** _____

EMPLOYER ADDRESS : _____

IF RETIRED **, FROM WHAT COMPANY :** _____

FAMILY PHYSICIAN : **BANK NAME :**

SPOUSE INFORMATION

NAME : _____ **BIRTHDATE :** _____

SOCIAL SECURITY # : _____ **CELL # :** _____

EMPLOYER : _____ **PHONE # :** _____

EMPLOYER ADDRESS :

NEAREST RELATIVE NOT LIVING WITH PATIENT : _____

ADDRESS : _____

RELATIONSHIP : _____ **PHONE # :** _____

FRIEND OR NEIGHBOR NOT LIVING WITH PATIENT : _____

ADDRESS: **PHONE # :**

PRIMARY INSURANCE NAME : _____ **SUBSCRIBER NAME :** _____

SUBSCRIBER RELATION : _____ **SUBSCRIBER DATE OF BIRTH :** _____

SECONDARY INSURANCE NAME : _____ **SUBSCRIBER NAME :** _____

SUBCRIBER RELATION : **SUBSCRIBER DATE OF BIRTH :**

*** PLEASE HAVE YOUR INSURANCE CARD(S) AND PHOTO I.D. READY AT CHECK-IN FOR US TO MAKE COPY***

Please bring the following to you appointment: Insurance cards & picture I.D, all nedications or a list of medications, and CD of testing if indicated (note: CDs will become patient records and not subject to return)

***** Co-insurance / co-pay is due at the time of appointment *****

INTEROFFICE ONLY: _____

NAME: _____ DOB: _____

PAST MEDICAL HISTORY:

☐Arthritis	☐Diabetes	☐High Cholesterol	☐Prostate Problem
☐Asthma	☐Emphysema	☐HIV Positive	☐Rheumatic Fever
☐Atrial Fibrillation	☐Fibromyalgia	☐Kidney Disease	☐Seizures
☐Bleeding Disorders	☐Glaucoma	☐Liver Disease	☐Stroke
☐Bronchitis	☐Gout	☐Multiple Sclerosis	☐Thyroid Problems
☐Cancer	☐Heart Attack	☐Pacemaker	☐Tuberculosis
☐Congestive Heart Failure	☐Hepatitis	☐Pneumonia	☐Ulcers

Other_____

_____

PAST SURGICAL HISTORY:

LIST ALL SURGERIES AND APPROXIMATE DATE

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

SOCIAL HISTORY:

Married, **Widowed**, **Single** or **Divorced** (circle one)

Number of children:_____

Do you smoke? Yes_____ No_____ How much?_____
How long?_____

Did you ever smoke? Yes_____ No_____ When did you quit?_____
How much?_____
How long?_____

Do you drink alcohol? Yes_____ No_____ If yes, how much?_____

Do you **currently work** or are you **retired**? (circle)

What type of work do you currently do or retired from? _____

FAMILY HISTORY:

Member	Age	State of Health	Age at Death	Cause
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____

NAME: _____ DOB: _____

MEDICATIONS:

(Please list all of your medications including inhalers, as well as vitamin and herb supplements.) Include name of medication, dose and number of times taken per day.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PHARMACY:

Name: _____ Phone #: _____

ALLERGIES: (Please list all of your medication allergies.)

_____ _____ _____
_____ _____ _____
_____ _____ _____

REVIEW OF SYSTEMS:

Have you had any recent weight **gain** or **loss** (circle) …… How many pounds_____Period of time_____
Have you had any unusual weakness or fatigue? Yes_____No_____
Do you have any **fever**, **chills** or **night sweats**? (circle) Yes_____No_____
Do you have any **dizziness, vision change** or **headaches**? (circle) Yes_____No_____
Do you have a hearing aid or hearing loss? (circle) Yes_____No_____
Do you have any nose **drainage** or **bleeding**? (circle) Yes_____No_____
Do you have any difficulty swallowing? Yes_____No_____
Do you have any hoarseness? Yes_____No_____
Do you have any unusual sinus problems? Yes_____No_____
Do you have any shortness of breath **with** or **without** exertion? (circle) Yes_____No_____
Do you have difficulty breathing while lying down? Yes_____No_____
Do you awaken at night short of breath? Yes_____No_____
Have you had any wheezing? Yes_____No_____
Have you coughed up **blood** or **sputum** recently? (circle) Yes_____No_____
Do you have any chest pain? Yes_____No_____
Have you had any loss of consciousness recently? Yes_____No_____
Have you had any pounding or racing of the heart? Yes_____No_____
Have you had any chest tightness or squeezing? Yes_____No_____
Have you had any **nausea** or **vomiting?** (circle) Yes_____No_____
Have you had any rectal bleeding, black or tarry stools? Yes_____No_____
Does it **burn** when you urinate or is there **blood** in your urine? (circle) Yes_____No_____
Do you have any muscle or back pain? Yes_____No_____
Have you had any cramps, pain or swelling in your legs? Yes_____No_____
Do you have any pain in your legs when you walk? (describe) _____
Do you have any color change in any of your extremities? Yes_____No_____
Do you have any unusual skin rashes or itching? Yes_____No_____
Have you had any changes in your speech or memory? Yes_____No_____
Have you had any seizures? Yes_____No_____
Have you been stressed, nervous, depressed? Yes_____No_____
Have you had any unusual bleeding? Yes_____No_____
Have you had any unusual swelling in the **glands of your neck**, **under your arms**, or in your **groin**? (circle) Yes_____No_____

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JOHN B. WEISS, M.D., F.A.C.S., F.A.C.C
RUSSELL H. WOOD, M.D., F.A.C.S., F.A.C.C., F.C.C.P.
JAMES S. COUNCE, M.D, F.A.C.C., F.C.C.P., F.A.C.C.
ROBERT C.JAGGERS, M.D., F.A.C.C.
CHARLES COLE, M.D.
KATHY SMITH, A.P.N., D.D.N.P.
RHAGEN PANYIK, P.A.
KRISTEN L. MARTINEZ, P.A.

Acknowledgement of Receipt

NOTICE OF PRIVACY PRACTICES

Your signature acknowledges that you received a copy of the Notice of Privacy Practices

PATIENT NAME: _____ **DOB** _____

SIGNATURE OF PATIENT: _____

DATE SIGNED: _____

PATIENT REPRESENTATIVE
(If Applicable): _____

RELATION OF REPRESENTATIVE: _____

RIGHT TO ACCESS

In order to protect your privacy, Cardiovascular and Thoracic Surgery Clinic asks you to list the family member, friends or any person(s) (including but not limited to spouses, significant others, and legal representatives) who can request or inquire regarding your Protected Health Information which includes medical condition and/or billing and financial information.

1. NAME _____ **RELATIONSHIP** _____ **PHONE** _____

ADDRESS _____

2. NAME _____ **RELATIONSHIP** _____ **PHONE** _____

ADDRESS _____

3. NAME _____ **RELATIONSHIP** _____ **PHONE** _____

ADDRESS _____

SIGNATURE: _____ **DATE** _____

(Parent/Guardian signature required if patient is under the age of 18)

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PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICARE POLICY

I request that payment of authorized Medicare benefits be made on my behalf to Cardiovascular Thoracic Surgical Clinic for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable for related services.

INSURANCE POLICY

We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductible, covered charged, co-payments, discounts, secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary.

We participate with numerous insurance companies. To "participate" means we accept that particular insurance company's allowables. This does not include your co-insurance, deductible or any service deemed patient responsibility by the rules of your specific insurance company or state assistance program. These are your financial responsibility. Please ask our office personnel if we have a participating contract with your insurance company.

NO-SHOW POLICY

It is very important that you call within 24 hours in advance to cancel your appointment. If for any reason you need to cancel or reschedule an appointment, please notify our office as soon as possible. On the second no-show or same-day cancellation/reschedule occurrence, there will be a $45 charge to your account and most often not covered by insurance. After three consecutive no-show occurrences, the practice reserves the right to terminate our relationship with you.

PAYMENT POLICY

Insurance Co-pays/co-insurance monies are due upfront at time of service. After all insurance monies have been received; you are immediately responsible for full payment of any remaining balance. If full payment cannot be made, it is your responsibility to contact our office to set up monthly payment plan.
YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet and have completed the answers on the first page. I certify this information is true and correct to the best knowledge. I will notify you of any changes in health status or the personal information.

Any information given to use will be used if needed to collect on a debt. We reserve the right to report delinquent balances to credit bureaus. We reserve the right to use a third-party collections agency, seek legal action, and/or petition the IRS under debtor intervention that may include IRS review/audit or a tax lien. We reserve the right to discontinue providing medical care if we are unable to collect for our services in a timely manner.

RELEASE OF EMPLOYMENT/STUDENT VERFICCATION

The Cardiovascular and Thoracic Surgery Clinic and/or the Center for Chest Care have my permission to verify current or past employment or proof of student enrollment.

MEDICATION REFILLS/NURSE CALLS

Pain medication refills may only be requested Monday through Thursday before 2:00pm. No pain medication refills/requests will be written on Fridays. Other medication refills may be requested through your pharmacy. Any nurse calls or medication requests received after 2:00pm may not be addressed until the next business day. We rarely follow medications on a long-term basis.

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

The Cardiovascular and Thoracic Surgery Clinic and/or the Center for Chest Care has my permission to request medical records from any and all medical doctors and/or medical facilities as needed relative to treatment. I release you from all legal responsibility that may arise from the act I have authorized above.

Signature :_____ **Date:** _____

(Parent Signature if patient under 18 years of age)

Patient Representative (if applicable): _____

Relation of Representative: _____