



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

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 : _____
SUBSCRIBER 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 medications 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:

- | | How many pounds | Period of time |
|--|-----------------|----------------|
| Have you had any recent weight gain or loss (circle) | _____ | _____ |
| 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 ___ | |



Cardiovascular and Thoracic Surgery

Washington Regional

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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)

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 VERIFICATION

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: _____