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 your 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:

<table>
<thead>
<tr>
<th>Member</th>
<th>Age</th>
<th>State of Health</th>
<th>Age at Death</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>_____</td>
<td>______</td>
<td>_____</td>
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<tr>
<td>Mother</td>
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<td>Brothers</td>
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<td>Sisters</td>
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<td></td>
<td>_____</td>
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<td>_____</td>
<td>______</td>
</tr>
</tbody>
</table>
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__
## NOTICE OF PRIVACY PRACTICES

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

<table>
<thead>
<tr>
<th>PATIENT NAME:</th>
<th>DOB:</th>
</tr>
</thead>
</table>

**SIGNATURE OF PATIENT:**

**DATE SIGNED:**

**PATIENT REPRESENTATIVE**

(If Applicable):

**RELATION OF REPRESENTATIVE:**

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### 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: __________________________**

(If applicable, please indicate the relationship of the representative and sign this document if the patient is under the age of 18. Please provide a date.)
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: _______________________

(Patient Signature if patient under 18 years of age)

Patient Representative (if applicable): ______________________________________________________

Relation of Representative: _______________________________________________________________