Cardiology and Vascular Associates, P.C.®

A Division of MHP Michigan Healthcare PROFESSIONALS

Thank you for making an appointment with our office. We look forward to meeting you. Please help us to prepare for your appointment by gathering the information we will need to make the most of your time with our provider(s). We require the following items:

1) Please fill out the paperwork provided in this envelope completely.
2) If any of the following have been ordered and/or performed, we will need you to contact the related company, service, physician, office, practice, hospital, and/or individual responsible for forwarding the reports of such. We will need these reports for your appointment:

- EKG
- Lab Work
- Chest X-Ray
- Stress Test
- Echocardiogram
- Holter Monitor
- Event Monitor
- Cardiac Catherization
- Cardiac Angioplasty
- Cardiac Bypass
- MUGA
- CT Scan
- Abdominal Ultrasound
- Carotid Ultrasound
- Extremity Ultrasound

(Or, any other reports, procedures, tests, etc. which you think may be beneficial for the physician to have)

3) Please bring your insurance card(s) and picture identification. We will need to make a copy of both.
4) Please bring a referral/authorization number if your insurance requires one.
5) Please be prepared to pay any co-pay or deductible that your insurance contract may require.
6) You will be asked to provide the office with an updated medication list (at check-in, prior to every visit), including vitamins, non-prescription drugs, and herbal supplements that you are taking or have taken recently.

Thank you for your cooperation with these requests and your efforts to supply us with all the necessary documentation for your visit with and continued care by Cardiology and Vascular Associates, P.C. Furnishing as much of the above information as possible will aid us in preventing repeated testing, and appointment rescheduling or delays.

Patient Name:_____ Date of Birth:_____

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ALL INFORMATION REQUESTED HERE IS REQUIRED IN ORDER TO PROPERLY BILL YOUR INSURANCE

DATE:_____ **DATE OF BIRTH:**_____ **AGE:**_____

NAME:_____ **SEX: M F**

STREET ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

MARITIAL STATUS: S M D W SPOUSE NAME:_____

SOCIAL SECURITY NUMBER:_____

HOME PHONE: (___) _____ **CELL PHONE:** (___) _____

(In providing my cell phone number I give you permission to contact me at this number.)

EMAIL ADDRESS:_____

OCCUPATION:_____ **EMPLOYER:**_____

EMPLOYER PHONE NUMBER: (___) _____

REFERRING PHYSICIAN:_____ **PHONE:** (___) _____

CITY:_____ **STATE:**_____ **ZIP:**_____

PRIMARY CARE PHYSICIAN:_____ **PHONE:** (___) _____

Insurance Subscriber

Please list the insurance subscriber (if subscriber is not patient)

SUBSCRIBER NAME:_____

SUBSCRIBER DATE OF BIRTH:_____

RELATIONSHIP TO PATIENT:_____

SUBSCRIBER SOCIAL SECURITY NUMBER:_____

PATIENT SIGNATURE:_____

Patient Name: _____
Date of Birth: _____

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MEDICATION LOG:

NAME:_____ **D.O.B.:**_____

KNOWN ALLERGIES:_____

_____

MEDICATION	DOSAGE	FREQUENCY

Patient Name:_____ Date of Birth:_____

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For all patients:

Due to recent healthcare reform laws and meaningful use requirements, we are mandated to request the following information:

1) Ethnicity
2) Race
3) Primary language

Please provide the following information:

Ethnicity:

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black and/or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White and/or Caucasian
- ☐ More than one race
- ☐ Other. Please specify:_____

Primary Language:

_____

The above collected information is only seen by the practice's registration staff, administrators and personnel involved in quality control, improvement, and oversight.. The confidentiality of information provided herein is protected by law. This information is entered directly into our computer system as anonymous data and your name is not collected anywhere on this form. This form will be destroyed after data entry.

You have the right to refuse to disclose and/or provide the above requested information. This refusal will not affect your status as a patient or the care provided to you. If you so desire, please indicate such refusal below.

☐ I hereby decline to disclose the information requested on this form.

Thank you for your cooperation.

Patient Name:_____ Date of Birth:_____

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PLEASE PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOU PREFERRED PHARMACY.

PRIMARY PHARMACY NAME:_____

PRIMARY PHARMACY ADDRESS:_____

PRIMARY PHARMACY PHONE NUMBER: (___)_____

PRIMARY PHARMACY FAX NUMBER: (___)_____

SECONDARY/MAIL PHARMACY NAME:_____

SECONDARY/MAIL PHARMACY ADDRESS:_____

SECONDARY/MAIL PHARMACY PHONE NUMBER: (___)_____

SECONDARY/MAIL PHARMACY FAX NUMBER: (___)_____

Patient Name:_____
Date of Birth:_____

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MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF

PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the **Michigan Healthcare Professionals, P.C.** Patient Notice of Privacy Practices effective September 23, 2013. I am aware that I can request a copy in the office or view online at any time.

Signature:_____ **Date:**_____

(or Guardian, if applicable)

[OPTIONAL]

Persons(s) with whom patient's information may be shared:

Name:_____ **Phone Number:**(____)_____

Relationship to Patient:_____

Name:_____ **Phone Number:**(____)_____

Relationship to Patient:_____

Name:_____ **Phone Number:**(____)_____

Relationship to Patient:_____

Patient Name:_____ Date of Birth:_____