LeConte Cardiology Associates

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):			SSN#	Birthdate	Age	Sex
Mailing Address			City, State, Zip			
Home Phone	Cell Phone		Email Address			
Marital Status	Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician	
Referring Physician	Referring Physician Contact #	Other Medical Providers				
Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White					Language	
Emergency Contact Name	Emergency Contact Phone #s Hm:		Cell:			
Employer Name and Address				Work Phone #		

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm:	Wk:	Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle	SSN#	Birthdate	Sex
Address	City, State, Zip		
Home Phone / Cell Phone / Work Phone		Relationship to patient	

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation

Are you here for workers compensation YES____NO____ Date:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident: _____

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____

Do you have a Power of Attorney? Yes_____ No_____

If yes to the above questions please make sure we have a copy for your medical record.

LeConte Cardiology Associates

responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMG's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to this Agreement are not effective or enforceable unless accepted in writing by a CMG corporate officer.

IX. CONTACTING PATIENT. Patient may be contacted at the following number: _____. In addition, ***please check one of the following***:

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name:_____Relation to patient:_____Phone:_____
Name:_____Relation to patient:_____Phone:_____

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than patient.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED _____ PRINTED NAME _____

PATIENT NAME _____ RELATIONSHIP TO PATIENT _____

DATE _____ TIME _____ AM/PM

A copy of this agreement will be provided on request.

CONSENT TO EMAIL AND/OR TEXT MESSAGE COMMUNICATIONS

This physician practice, LeConte Cardiology Associates, has the ability to send email and/or text messages to patients reminding them of upcoming appointments. The Practice also may send an email or text message after appointments with a link to a brief survey in order to allow the Practice to improve quality and service.

Consent to Email and/or Text Communications. By signing below, I authorize the Practice to contact me by email and/or text message for appointment reminders, survey requests, and other health-related communications using the cellular telephone number and/or email address I have provided on my patient intake forms.

Security Advisement. I understand that text messaging and email are not secure forms of communication and information contained in texts and emails sent to the telephone number or email address I have provided could be accessed or used by unauthorized third parties. I further understand that my wireless carrier may charge for text messages and that these messages may come from an automated dialing system. By signing below, I understand and agree not to include any sensitive or private information in any responses to surveys I receive, because such survey responses are not transmitted by secure means and could be intercepted by unauthorized third parties.

Opt Out. I understand that I may opt out of receiving text messages and/or email communications at any time by contacting the Practice.

Signature: _____

Name: _____

Date: _____

APPOINTMENT CANCELLATION & NO SHOW POLICY

Last minute cancellation and same day no-shows make it difficult to serve other patients who are waiting to be scheduled. We ask that you give a twenty four (24) hour notice of cancellation or reschedule prior to you appointment if you will be unable to keep that appointment. We will be happy to reschedule your appointment. Scheduled appointments that you do not show up for, will result in a $25.00 fee. No show fees are the sole responsibility of the patient and will be billed to the patient.

Patient Printed Name: _____

D.O.B. _____

Signature: _____

Relationship to Patient:

☐ Self ☐ Other: _____

Date: _____

HEALTH MAINTENANCE QUESTIONNAIRE
PART I

Patient Name:_____ *(Please Print)* Date of Birth: _____

Date:_____ Age:_____

TOBACCO QUESTIONNAIRE:

Have you ever used Tobacco Products? Yes No

Tobacco Type:	Use Daily:	Usage per day:		Years Used:	Age Stopped:	Tobacco Type:	Use Daily:	Usage per day:		Years Used:	Age Started:	Age Stopped:
☐ Cigarette	☐					☐ Chewing	☐		Units			
☐ Cigarillo	☐		Cigarillos			☐ Smokeless	☐		Units			
☐ Cigar	☐		Cigars			☐ Snuff	☐		Units			
☐ Pipe	☐		Pipes									

Are you considering quitting your use of tobacco? YES NO

Have you attempted to quit before? YES NO

If yes:

When did you attempt to quit? _____

What method did you use? _____

How long were you tobacco free?_____

Have you had your FLU Shot? (Patients 6 months and older) YES NO

When?_____ Provider?_____

Have you had your Pneumonia Shot? (Patients 65 years and older) YES NO

When?_____ Provider?_____

Have you had your Shingles Shot? (Patients 60 years and older) YES NO

When?_____ Provider?_____

Have you had a Colonoscopy or Sigmoidoscopy? (Patients 50 to 75 years old) YES NO

When?_____ Provider?_____

Have you had a Fecal Occult Stool Test? (Patients 50 to 75 years old) YES NO

When?_____ Provider?_____

Have you had a Mammogram? (Female Patients 40 to 74 years old) YES NO

When?_____ Provider?_____

Have you had a DEXA Scan for osteoporosis screening? (Patients 65 years and older) YES NO

When?_____ Provider?_____

Have you had a PAP Smear in the last 3 years? (Female Patients) YES NO

Have you had a Hysterectomy? (Female Patients) YES NO

Have you had any falls in the last year? (Patients 65 years and older) YES NO

If so, did the fall result in injury? YES NO

What kind of injury? _____

Recent Hospitalization: Yes No Date:_____ Facility: _____

Signature: Patient (or Patient's Legally Authorized Representative)

Signed_____ **Date**_____

PATIENT NAME: _____

REVIEW OF SYSTEMS

HAVE YOU HAD ANY OF THE FOLLOWING RECENTLY?

GENERAL

FATIQUE/ENERGY	YES	NO
FEVER/RECENT INFECTION	YES	NO
WEIGHT LOSS	YES	NO
NIGHT SWEATS	YES	NO

EYES

MACULAR DEGENERATION	YES	NO
BLURRED/DOUBLE VISION	YES	NO
SPOTS/FLOATERS	YES	NO
CATARACTS	YES	NO

ENT

EAR INFECTION/PAIN	YES	NO
RINGING IN THE EARS	YES	NO
DIZZINESS/VERTIGO	YES	NO
SINUS INFECTION/DRAINAGE	YES	NO

RESPIRATORY

COUGH/BRONCHITIS	YES	NO
SHORTNESS OF BREATH	YES	NO
SMOTHERING AT NIGHT	YES	NO
ASTHMA/WHEEZING	YES	NO

GASTROINTESTINAL

STOMACH BLEEDING	YES	NO
BOWEL BLEEDING	YES	NO
CHANGE IN BOWEL HABITS	YES	NO
PROBLEMS SWALLOWING/REFLUX	YES	NO

GENITOURINARY

KIDNEY DISEASE	YES	NO
BLEEDING FROM KIDNEYS	YES	NO
BURNING WHEN KIDNEYS ACT	YES	NO
KIDNEY STONES	YES	NO
PROSTATE PROBLEMS (MEN)	YES	NO

MUSCULOSKELETAL

ARTHRITIS/JOINT PAIN/STIFFNESS	YES	NO
BACK/JAW PAIN	YES	NO
MUSCLE SORENESS/ ACHES/TENDERNESS	YES	NO
FRACTURES/JOINT REPLACEMENT	YES	NO

SKIN

SKIN DISEASE/RASH	YES	NO

NEUROLOGICAL

FAINTING SPELLS	YES	NO
SEIZURES/TREMORS	YES	NO
HISTORY OF TIA, STROKE	YES	NO
NEUROPATHY/WEAKNESS	YES	NO
HEADACHES/MIGRAINES	YES	NO

CARDIOLOGY

CHEST PAIN	YES	NO
SWELLING/EDEMA	YES	NO
RACING/PALPITATIONS	YES	NO

PSYCHIATRIC

ANXIETY/NERVES	YES	NO
DEPRESSION	YES	NO
BIPOLAR	YES	NO

ENDOCRINE

THYROID PROBLEMS	YES	NO
DIABETES	YES	NO

HEMATOLOGICAL

UNEXPECTED BLEEDING	YES	NO
MAJOR BRUISING	YES	NO
ANEMIA/LOW BLOOD	YES	NO

LIST RECENT SURGERIES OR PROCEDURES

_____

_____

_____

RECENT DOCTOR VISITS

_____

_____

_____