ETSU HEART
ETSU Physicians and Associates

Cardiology New Patient Information

Name:_____ **Birth Date:**_____ **Home Phone:**_____ **Cell Phone:**_____ **Email:**_____	**Primary Language:** _____ **Race:**_____ **Primary Care Physician:** _____	**Drug Allergies:**_____ _____ _____ _____
Address (Street/City/State/Zip): _____	**Employer:** _____ **Employer Phone:** _____	**Marital Status: (circle one)** **S M W D Sep** **SSN:**_____
Emergency Contact Name/Address: _____ _____	**Emergency Phone:** _____	**Relationship:** _____
Insurance Coverage: (i.e. Blue Cross) _____	**Effective Date:** _____	
Insurance Holder's Name: _____ **Relationship:** _____	**Insurance Holder's Address:** ☐ **Check if same as patient** _____ _____	**Insurance Holder's Phone:** _____ **Insurance Holder's Birth Date:** _____
Insurance Holder's Employer: _____ **Insurance Holder's Employer Phone:** _____	**Responsible Party Name:** _____ **Phone Number:** _____	

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Patient History

Name_____ Date of Birth _____ Today's Date _____

List any allergies you have and what your reactions are

1._____

2._____

3._____

4._____

Have you ever had the following?

____Diabetes ____Thyroid Disease ____Heart Disease

____High or Low Blood Pressure ____Rheumatic Fever ____Asthma or Emphysema

____Pneumonia ____ Hepatitis or Jaundice ____ Tuberculosis or Exposure to TB

____Bleeding Tendency ____Anemia ____Cancer

____Blood Transfusions ____Kidney Disease ____ Stroke

Social History

Occupation_____ Previous Occupation_____

____I live alone ____I live with spouse ____Other

Education ____Years High School ____Years College ____Years Post Graduate

Use of alcohol ____Never ____Rarely ____One or two drinks occasionally ____Daily ____Drinks/Day

Use of tobacco ____Never ____Previously ____Packs/day for___years, but quit _____

Use Smokeless? Y N Caffeine Intake: Cups/glasses (tea, coke, coffee) _____per day

Family History	Age	Medical Problems	If deceased, age and cause
Father			
Mother			
Brothers			
Sisters			
Husband/Wife			
Children			

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Cardiac History Assessment

Symptoms	**Yes**	**No**	**Explain**
Chest pains/pressures			
Ordinary exercise poorly tolerated			
(Undue) shortness of breath			
Lightheadedness/fainting			
Palpitations/heart racing			
Irregular heartbeat			
Atrial fibrillation			
Slow heartbeat			
Cardiac arrest (resuscitation)			
Stroke symptoms			
Walking-induced leg cramp/pain			
Previous Procedures	**Yes**	**No**	**Date, Location**
Treadmill test			
Heart scan			
Cardiac echo			
Carotid ultrasound/duplex			
Holter (ambulatory ECG)			
Event recorder			
Cardiac cath/coronary angio			
Coronary angioplasty/stent			
Coronary bypass surgery			
Open heart surgery			
Artificial heart valve			
Cardiac pacemaker/defibrillator			
"Risk Factors"	**Yes**	**No**	**Duration in Years**
High blood pressure			
High blood cholesterol			
High blood sugar/diabetes			
High body weight (overweight/obesity)			
Sleep Apnea			
Smoking			
Current/Previous Treatments	**Yes**	**No**	**Date (Year) Started**
Blood pressure med's			
Diuretic			
Anti-diabetic med's (by mouth)			
Insulin (injected, inhaled)			
Cholesterol-lowering medication			
Anti-arrhythmic med's			**Brand**
Anti-platelet agents			
Plavix			
Aspirin			
Coumadin (Warfarin) "blood thinner"			

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Insurance Authorization and Assignment

I request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to Quillen ETSU Physicians for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.
I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carries any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

I hereby authorize Quillen ETSU Physicians to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. This authorization is valid as long as I am a patient at Quillen ETSU Physicians.
I am responsible for all financial obligations of health services for the above patient; and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collection costs and reasonable legal fees.

_____ _____

Signature of Patient Date

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Due to the problem of over utilizing prescriptions of controlled substances, we have a policy, within our office, not to prescribe such medications at new patient visits. New patients will be required to sign the below policy before being seen. If, after reviewing the below policy, you do not agree and choose not to sign, your new patient appointment will be canceled.

Controlled Substance Prescriptions for New Patients – Policy

Controlled substance overuse and abuse has become a major problem. Controlled substances include narcotic pain medications (i.e. codeine, hydrocodone, oxycodone, morphine, fantanyl, lortab, Percocet, tylox, vicodin, oxycontin, kadian, MS contin, avinza and dilaudid), certain nerve medications (i.e. diazepam, alprazolam, lorazepam, valium, xanax, ativan) and other medications.

Many patients who are taking these come to us as new patients expecting that our physicians will prescribe these medications on the first visit. It is our policy that we will not prescribe such medications at a new patient visit, except under the most extreme and well documented conditions. If you are on such medications and feel that you need to continue them, you will need to make other arrangements to obtain them. If this policy is not acceptable to you, you may cancel your new patient appointment and seek care elsewhere.

We may or may not prescribe such medications to you in the future. Each patient will be evaluated on a case-by-case basis once enough information is available to make a clear diagnosis. This generally includes reviewing medical records from your previous doctors and performing appropriate tests. Although another physician (outside our group) has chosen to prescribe such medications, this does not mean that we will agree to continue those medications. Quillen ETSU Physicians believes that it is not usually in the best interest of the patient to take addictive medications on a long term basis

I have read and understand the above policy regarding controlled substances:

_____ _____

Signature of Patient Date

Quillen ETSU Physicians has developed this mutual agreement to pertain to the treatment of any medical conditions. I understand that the goal of treatment is to improve my functional ability, and in so doing, that sometimes requires narcotics, sedatives, and/or tranquillizers. These medications sometimes lead to abuse and dependency, though if used correctly can be effective. By initialing and signing in the appropriate areas below, I acknowledge my responsibility to uphold this agreement.

_____I agree to obtain my prescriptions related to my chronic medical conditions only from my primary care physician or another physician within the same office. If any other physician provides these same prescriptions, then I will immediately update my physician or I may be dismissed.

_____I will not ask for any medication to be dispensed early and I will allow 72 hours for these medications to be filled.

_____I will not share or trade medication with anyone.

_____I will take the medication only as prescribed and I will not adjust the dosage without first discussing these changes with my physician.

_____I will obtain my prescription refills only during regular office hours, not on weekends or after office hours. I will only use one pharmacy for my prescriptions.

_____I will bring unused medications in for random pill counts and provide random drug screens when requested as these medications have abuse potential. I understand that because these medications have abuse potential, I will participate in any drug rehabilitation and detoxification programs that are advised for my health.

_____Once a prescription is written, I am responsible for all of my pills. If they are lost, stolen, misplaced, or disappear for any reason, I will not ask for any medications early.

_____I will authorize my physician to cooperate with any and all authorities, as these medications are monitored by governmental agencies.

_____I understand that while taking these medications my ability to drive and operate machinery may be impaired and I release my physician of any and all liability stemming from my impairment.

_____I understand random drug test screens will be performed. If I am unable to give a sample when requested or that the detection of illegal substances or unauthorized medications are present in the result I may be dismissed. If the results do not detect prescribed medications I may be dismissed.

_____I understand any altering of original prescriptions will result in dismissal. Failure to keep appointments, except in cases of emergency, may also result in dismissal.

By signing below, I have read and agree with the above statements and policies. A copy has been provided to me for my own reference. Failure to comply with any of the above statements may result in my dismissal from this practice.

_____ _____

Signature of Patient Date

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Teaching Physicians

You will be seen by a physician who is a member of the faculty of the James H. Quillen College of Medicine. The physicians, who work in this office, as part of their faculty responsibilities are responsible for teaching medical students, residents (post graduate trainees), and fellows. Not only will you see your own physician, but one or more medical student(s), resident, and/or fellow may also see you. This is part of the mission of the Quillen College of Medicine. We believe this adds to the depth and level of care the patient receives since patients are seen by one more or physicians and discussed in detail.

Several thousand patients receive their medical care through our offices and enjoy helping our teaching programs. 'We are pleased with your willingness to participate in our teaching program and your care shall encompass a team approach to health care with involvement of your physician, resident, fellow, medical students, and other medical trainees."

_____ _____

Signature of Patient Date

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Advanced Directives Information

REGARDING YOUR RIGHT TO MAKE ADVANCE HEALTH CARE DECISIONS

Federal law requires that we give you information about your right to make advance health care decisions. Right now, you may be able to make your own health care decisions. You may not always be able to make such decisions, however. By giving advance directions, you can tell your health care provider and family about the medical care you would like to receive and whether you want another person to be able to accept or refuse treatment for you.

You can leave advance directions about withdrawal of life support by executing a "Living Will." A Living Will authorizes your health care provider and family to withdrawal or withhold medical care which artificially prolongs life, in the event your attending physician determines you have a terminal condition from which there is no reasonable expectation of recovery. You can also name a person to make medical treatment decisions for you by appointing someone to have a "Durable Power of Attorney for Health Care" for you. This person is allowed to make health care decisions for you, including life support decisions. It may also direct the attending physician with respect to donations of your organs. It is our policy to honor a patient's health care decisions to the full extent required by law. You are NOT required to give advance health care directions in order to receive care at this facility.

Do you have a Living Will? Yes___ No___

Do you have a Durable Power of Attorney for Health Care? Yes___ No___

If you answered YES to either of the questions, we need to put a copy of the document in your medical chart in order to be sure that your wishes are honored.

_____ _____ _____

Print Name Signature of Patient Date

Patient Message Authorization Notice

Please read, check the appropriate items, sign and date. If no items are checked, the medical staff CANNOT leave any messages even if you have signed this notice.

I authorize Quillen ETSU Physicians medical staff to leave a message regarding:

___ Appointments

___ Lab results

Phone (____)_____ ___

Also, I give permission to Quillen ETSU Physicians to speak with and release my medical information to the following individuals regarding my health information.

Name	Relationship

___ I decline to have any healthcare related information left on my voicemail.

___ I decline to designate anyone to speak to Quillen ETSU Physicians on my behalf.

_____
Name (please print)

_____ _____
Signature Date