



Nima Aghili, MD	Lawrence D. Lazar, MD	Hannah Baird, PA-C
John. D Altman, MD	David Liff, MD	Fe Bernardo, NP-C
James Beckmann, MD	Michael J. Ptasnik, MD	Stephanie Davidson PA-C
Norman A. Gray, MD	Layth Saleh, MD	Tim Covi PA-C
David Halpin, MD	Kristin D. Thanavaro, MD	William Fuller, PA-C
Takeshi Kataoka, MD	Ganesh Venkataraman, MD	Megan Punt, PA-C
		Kim Riemer, NP-C

Date: _____

Patient Information

Last Name: _____ First Name: _____ M.I: _____

Social Security #: _____ Date of Birth: _____ Gender: Male Female

Address: _____ Apt# _____ Driver's License #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Email address: _____

For the bolded questions below, please answer in the spaces provided or circle all answers that apply to you.

Race:

Asian Black/African American Native American White Other Unknown or not reported

Ethnicity:

Hispanic or Latino Not Hispanic or Latino Unknown or decline to report

Language:

English Spanish Russian Refused to Report Unreported Other

Other Physicians:

Primary Care Physician: _____ Phone Number: (____) _____

Referring Physician: _____ Phone Number: (____) _____

Marital Status:

Married Single Divorced Widowed/Widower Life partner

Children:

Yes No Number of Sons: _____ Number of Daughters: _____

Employment Status:

Employed Retired Unemployed

Employer: _____ Occupation: _____

Address: _____ Phone number:(____) _____

Name: _____

DOB: _____

In the space below please describe your problem(s) that you are having now. Please include when the problem first presented, how severe your problem is and any contributing factors to your ailment.

Have you ever used tobacco?

No/ Never Yes, formerly Yes, currently

Tobacco Type:

Cigarettes Chewing Tobacco Pipe Tobacco Snuff

Age Started: _____ Age Stopped: _____

Quantity per Day: _____ Total years used: _____

Diabetes: Have you ever been diagnosed with diabetes?

Yes No Unknown

Type: 1 2 Year Diagnosed: _____

Dyslipidemia: Have you ever had abnormal Cholesterol?

Yes No Unknown

Type: _____ Year Diagnosed: _____

Family History Premature Coronary Artery Disease Has anyone in your family younger than the age of 60 had Coronary Artery Disease?

Yes No Unknown Adopted

Hypertension Have you ever been diagnosed with high blood pressure

Yes No Unknown Year Diagnosed: _____

Peripheral Vascular Disease: Have you ever been diagnosed with PVD?

Yes No Unknown Year Diagnosed: _____

Alcohol consumption: Do you drink alcohol?

Yes No

Frequency: _____ Amount: _____ Last Drink: _____

Caffeine Consumption: Do you drink/ consume caffeine?

Yes No

Type(s): _____ Frequency: _____ Amount: _____

Recreational Drug Use: Do you use any drugs recreationally, including marijuana?

Yes No

Type(s): _____ Frequency: _____ Amount: _____

_____ **Please initial here if you consent to having confidential information in Social History Document**

Name: _____

DOB: _____

In the space below, please note your family members current health status to better allow us to treat you. Specifically, please note if your family members have a history of coronary artery disease, heart attacks, high blood pressure, high cholesterol, stroke, diabetes, sudden death, heart failure and/ or cancer? (Please circle Alive and Well, Alive and diagnosed or Deceased; then note the cause of death or diagnosis if known and the age at which the disease was first diagnosed)

If you were adopted please initial here _____

Father:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset: _____

Mother:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset: _____

Brother:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset: _____

Sister:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset: _____

Daughter:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset: _____

Son:

Alive and Well Alive and diagnosed Deceased

Diagnosis or Cause of Death/ Age of disease onset: _____

In the space below please include grandparents or other family members not listed above.

Past medical history (Circle all that apply)

- | | | |
|-------------------------|----------------------|-----------------------|
| Heart Disease | Lung problems | Liver Disease |
| Heart Valve Problems | Kidney Disease | Bleeding |
| Blood clot in the Lungs | Thyroid disease | Pacemaker |
| Heart Failure | HIV disease/exposure | Heart Block |
| Hereditary Heart Defect | Diabetes | Previous Heart Attack |
| Heart Murmur | Stroke/TIA | High Blood Pressure |
| Blood Clot in the Legs | Asthma | Emphysema |
| Hepatitis (A, B, or C) | Cancer | |

Comments:

Name: _____

DOB: _____

Please provide information about previous SURGERIES (Include date or Year)

Coronary Bypass: _____

Date: _____

Cardiac Cath/ Angiogram/ Stent: _____

Date: _____

Pacemaker/ ICD: _____

Date: _____

Please List any Medication Allergies and Drug Reaction:

Pharmacy Name and Phone number: _____

Please use the space below, and present at the time of your appointment, a list of all of your current medications, vitamins, and supplements. This will help us better serve you. Thank you!

Please print clearly.

Name of Medication (s)	Dose	Amount Taken Daily
	(Mg/ mcg/ etc)	(How many tablets, caps or injections per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Use the back of this page as needed

Name: _____

DOB: _____

PERMISSION TO COMMUNICATE PROTECTED HEALTH INFORMATION

I grant permission to Colorado Heart & Vascular, P.C. to disclose Health information in the following manner:

By my initials, I recognize that electronic mail is **Not** a secure form of communication.

Communicate information via electronic mail: _____

Leave a message on my voicemail/answering machine at home: _____ Phone #: _____

Leave a message on my voicemail/answering machine at work: _____ Phone #: _____

Leave a message on my voicemail on my mobile phone: _____ Phone #: _____

*****EMERGENCY CONTACT AND PERMISSION TO COMMUNICATE*****

Please fill in the following questions and circle selected options that apply to you.

Name: _____ Relationship: _____ Ph: _____
Leave Msg Ok to speak with No communication unless urgent

Name: _____ Relationship: _____ Ph: _____
Leave Msg Ok to speak with No communication unless urgent

Name: _____ Relationship: _____ Ph: _____
Leave Msg Ok to speak with No communication unless urgent

The type and amount of information that I authorize to be disclosed is as follows (please circle all answers):

- Laboratory Results Radiology Results (X-rays, ultrasounds, etc.) Billing information
- Prescription drug information Medical instructions or advice Insurance information
- Appointment information, including confirmation/cancellation of appointment and type of appointment.

By signing this form, I understand that protected health information may be left on an answering machine as I have indicated above.

Signature of Patient or Authorized Representative

Date

Name: _____

DOB: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you may have access to this information. Please review carefully!

Colorado Heart & Vascular, P.C. is permitted by Federal Privacy laws to make uses and disclosures for your health information for purposes of treatment, payment and health care operations.

We use health information about you, for your treatment, to be paid for your treatment, for continuity of care by sharing your information with other physicians involved in your total care and for various quality of care evaluations and outcome evaluations.

Our practice may contact patients to provide appointment reminders or information reminders of information about treatment alternatives or other health related benefits and service that may be of interest to you. This information may be shared by land mail, e-mail, fax, telephone, or other methods. Colorado Heart & Vascular P.C. will attempt to accommodate reasonable requests, made in writing, to communicate by alternative means or at alternative locations.

We may have to disclose personal health information about you without your authorization for public health activities; to your family if you are seriously ill and unable to communicate; for reporting abuse, neglect or domestic violence; for health oversight activities; for judicial and administrative proceeding; for law enforcement purpose; for organ donations; for coroners, medical examiners and funeral directors; for specialized government functions and to avert serious threat to health and safety.

Our practice may disclose information to research when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Other uses and disclosures will be made only as otherwise required by law or with your written authorization. Such authorization may be revoked later, stop future uses or disclosures.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are physical property of Colorado Heart & Vascular P.C. The information in the records, however, belongs to you. **You have the right to:**

- Request a restriction on the use and disclosure of certain health information - **we are not required to grant the request**; unless the individual pays for the health care item or service in full on an out-of-pocket basis;
- Receive confidential information by alternative means or at alternative locations - we will attempt to accommodate reasonable requests presented to Colorado Heart & Vascular P.C. in writing;
- To inspect and obtain a copy, at normal photocopy costs, of your confidential information - if Colorado Heart & Vascular P.C. maintains the individual's PHI as an electronic health record, the individual also has the right to request and receive the PHI in electronic form - requests should be presented in writing - there may be legal exceptions to this right - you may contest the denial of access to your information by writing to Colorado Heart & Vascular P.C.'s HIPAA Compliance Officer;
- To request in writing that we amend your confidential information or change your demographic information. You must provide the reason for the request. We may deny your request for amendment if we determine that: we did not create the information; the law does not allow you to amend the information; your request to amend is denied, you will be told the reason and you may submit a statement showing why you disagree with the decision and this statement will be kept with your records;
- To receive an accounting of disclosures of your confidential information for uses other than disclosures of intimation for treatment, payment or healthcare operations during the prior three years;
- To receive a paper copy of the notice

Name: _____

DOB: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of Colorado Heart & Vascular, PC's Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about Colorado Heart & Vascular, PC's privacy practices or my rights with regard to my personal health information, I may contact your Compliance Officer at: 11700 W. 2nd Pl. Ste 350, Lakewood, CO 80228, 303-595-2727 for further information as set forth in the notice.

Printed Name of Patient or Patient Representative

Patient's Date of Birth

Signature of Patient or Patient Representative

Date

If signed by Patient's personal representative, State Representative's authority to act on behalf of the patient.

*****STAFF USE ONLY*****

**DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN
ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES**

Patient Name: _____

Patient's Date of Birth: _____

I hereby certify on ___/___/___ (MM/DD/YR), I made a good faith effort to obtain the above patient's written acknowledgment of receipt of Colorado Heart & Vascular, PC's Notice of Privacy Practices, but I was unable to do so for the following reason(s).

Name of Staff Person

Signature of Staff Person

Date

**NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S
MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES.**

Colorado Regional Health Information Organization

Colorado Heart & Vascular, PC endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

Name: _____

DOB: _____

Primary Insurance Information

Insurance Name: _____

Phone: _____

Address: _____ City: _____ State: _____
Zip: _____

Member ID/Policy #: _____ Group #: _____

Copay: _____

Primary Policy Holder Name: Last: _____ First: _____

Date of Birth: ____/____/____ SSN: _____ - _____ - _____
Sex: M F

Relationship to Patient _____

Secondary Insurance Information

Insurance Name: _____

Phone: _____

Address: _____ City: _____ State: _____
Zip: _____

Member ID/Policy #: _____ Group #: _____

Copay: _____

Primary Policy Holder Name: Last: _____ First: _____

Date of Birth: ____/____/____ SSN: _____ - _____ - _____
Sex: M F

Relationship to Patient _____

Emergency Contact (not at same address): _____ Relationship: _____

Home Phone:(____)_____ Work:(____)_____ Cell:(____)_____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/ or surgical benefit for services rendered by Colorado Heart & Vascular, P.C. to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Colorado Heart & Vascular, P.C.

I understand that I am financially responsible for the amount not covered by insurance including, co-payments, co-insurance, and deductibles. I also agree that it is my responsibility to understand my insurance coverage and to verify that appropriate referrals, or pre-authorizations required by my insurance coverage are in place before the service is rendered. A photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release information necessary to secure payment. The assignment will remain in effect until revoked by me in writing.

Signature of Patient or Authorized Representative

Date