700 Shadow Lane, Suite 166
Las Vegas, NV 89106
702-258-1601 * 702-870-1995 fax
www.CCCDOC.com

Patient Information

Name: ____ Social Security: ___________________________
First   Middle   Last

Date of Birth: ____________________________________ ***Sex (Circle One):*** *Male / Female*

Address: ____City: ______________State: ______ Zip Code: ___________

Home Phone: ______________________Cell Phone: _____________________Work Phone: _______________________

Preferred Contact Number (Circle One): *Home / Cell / Work* ***Primary Language Spoken:*** *English / Spanish / Other*

Race/Ethnicity: *Caucasian / African American / Hispanic / Asian / No Answer / Other* ___________________

Marital Status: *Single / Married / Widowed/ Separated* Email: ____

Are you currently: *Employed / Retired / Disabled / Full-Time Student* Employer: ________________________________

Is your spouse currently employed? Y / N

Spouse's Name: ____Social Security: __________________________

Spouse's DOB: __________________________

Primary Care Doctor: ____Phone #: ____________________________

Referring Doctor (if different from Primary): ________________________________ Phone #: _____________________

Emergency Contact: __________________________________Phone #: ___________________Relationship:_______________

Do you have insurance? Y / N Is your condition under a Workman's Comp Claim or A Personal Injury Case? Y / N

Do you have a secondary/supplemental policy? Y / N Have you ever served in the military? Y / N

Have you made any changes to your choice of Medicare options in the last enrollment period? Y / N

Are you enrolled in a Medicare Advantage Plan? Y / N

How did you hear about us: *Doctor Referral / Patient Referral / Website / Yellow Pages / Insurance / Self-referral*

I may have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature _______________________________ **Date** _________________________

MEDICATION LOG

Patient Name ______________________ **Patient ID** ______________________

Physician ____

Medication	Dose	Schedule				
		1 x a day	2 x a day	3 x a day	4 x a day	As needed
		1 x a day	2 x a day	3 x a day	4 x a day	As needed
		1 x a day	2 x a day	3 x a day	4 x a day	As needed
		1 x a day	2 x a day	3 x a day	4 x a day	As needed
		1 x a day	2 x a day	3 x a day	4 x a day	As needed
		1 x a day	2 x a day	3 x a day	4 x a day	As needed
		1 x a day	2 x a day	3 x a day	4 x a day	As needed
		1 x a day	2 x a day	3 x a day	4 x a day	As needed
		1 x a day	2 x a day	3 x a day	4 x a day	As needed
		1 x a day	2 x a day	3 x a day	4 x a day	As needed
		1 x a day	2 x a day	3 x a day	4 x a day	As needed

**** Refer to your prescription bottles for accuracy**

Name	Date of Birth

HEALTH HISTORY QUESTIONNAIRE (CONFIDENTIAL)

1. Have you had any health problems in the past five (5) years? .... Yes No
2. Have you seen a physiciahn or other healthcare provider in the past two (2) years? .... Yes No
3. Have you been hosptialized or had a serious illness in the past five (5) years? .... Yes No

Please circle the appropriate response if you have ever had the following; if un sure, do not answer the question.

HEART/BLOOD VESSELS		
Rheumatic Fever	Yes	No
Rheumatic Heart Dx	Yes	No
Heart Valve Damage	Yes	No
Heart Murmur	Yes	No
Congenital Heart Defect	Yes	No
Artificial Heart Valve	Yes	No
High Blood Pressure	Yes	No
Heart Attack (Date__________)	Yes	No
TIA/Stroke (Date____________)	Yes	No
Heart Surgery (Date__________)	Yes	No
Vascular Surgery (Date______)	Yes	No
Pacemaker	Yes	No
Coronary Heart Dx	Yes	No
Congestive Heart Failure	Yes	No
Angina Pectoris/Chest Pain	Yes	No
Irregular/Rapid Heart Beats	Yes	No
Other Heart or Vessel Disorder	Yes	No
BLOOD		
Blood clots or thrombosis	Yes	No
Anemia	Yes	No
Sickle Cell Disease/Trait	Yes	No
Transfusion (Date____________)	Yes	No
Hemophilia	Yes	No
Bruise easily	Yes	No
Other Blood Disorder	Yes	No
NERVOUS SYSTEM		
Epilepsy	Yes	No
Seizure Disorder	Yes	No
Multiple Sclerosis	Yes	No
Trigeminal Neuralgia	Yes	No
Chronic Pain	Yes	No
Anxiety/Depression	Yes	No
Alzheimer's Disease/Dementia	Yes	No
Psychiartric Treatment	Yes	No
Persistent Dizziness/Fainting	Yes	No
Persistent Numbness/Tingling	Yes	No
Other Nervous/Mental Disorder	Yes	No

HEAD AND NECK	Yes	No
Glaucoma	Yes	No
Chronic Sinusitis	Yes	No
Headaches	Yes	No
Unexplaned Visual Changes	Yes	No
Freqent or Severe Nosebleeds	Yes	No
Persistent Sore Throat/ Hoarseness	Yes	No
Recent Difficult Swallowing	Yes	No
Injury to Head, neck, jaw	Yes	No
Other Head or Neck disorder	Yes	No
ENDOCRINE		
Diabetes	Yes	No
Low Thyroid	Yes	No
Other Thyroid Conditon	Yes	No
Cushings Syndrome	Yes	No
Other Endocrine Condition	Yes	No
MUSCULOSKELETAL/CONNECTIVE TISSUE		
Sjogren's Syndrome	Yes	No
Arthirits	Yes	No
Artificial Joint (Date__________)	Yes	No
Fibromyalgia/Rheumatism	Yes	No
Chronic Back pain	Yes	No
Other Muscle or Bone Disorder	Yes	No
RESPIRATORY		
Tuberculosis (TB)	Yes	No
Asthma	Yes	No
Chronic Bronchitis	Yes	No
Emphysema	Yes	No
Persistent Cough	Yes	No
Cough up Bloody Sputum	Yes	No
Shortness of Breath	Yes	No
Sleep Apnea	Yes	No
Other Respiratory Disorder	Yes	No

LIVER/DIGESTIVE		
Hepatitis	Yes	No
Cirrhosis of the Liver Liver Disease	Yes	No
Ulcers	Yes	No
Jaundice	Yes	No
Frequent Heartburn	Yes	No
Frequent Nausea/Vomiting	Yes	No
Other Digestive Disorder	Yes	No
CANCER HISTORY		
Cancer	Yes	No
If yes, what type		
Leukemia	Yes	No
Beign Tumors/Growths	Yes	No
Type of Treatment		
Surgery	Yes	No
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Hormone Therapy	Yes	No
IV Biophosphates (Zometa or Aredia)	Yes	No
ALLERGY HISTORY		
Are you allergic to or have you had a bad reaction to any of the following?	Yes	No
Penicillin	Yes	No
Sulfa Drugs	Yes	No
Other Antibiotics	Yes	No
Aspirin	Yes	No
Latex Products	Yes	No
Metals, including jewelry	Yes	No
Surgical Anesthetics	Yes	No
Contrast	Yes	No
Other Allergy	Yes	No
URINARY TRACT		
Kidney Disease	Yes	No
Renal Dialysis	Yes	No
Venereal Disease	Yes	No
Sexually Transmitted Disease	Yes	No
Other Urinary Tract Disorder	Yes	No

PLEASE CONTINUE OTHER SIDE

Name	Date of Birth

Please circle the appropriate response. If you are not sure, do not answer the question.

FAMILY HISTORY

Has an immdiate family member had any of the following?

Diabetes	Yes	No	Father	Mother	Sister	Brother	Child(ren)	Other ___________
Heart Disease	Yes	No	Father	Mother	Sister	Brother	Child(ren)	Other ___________
Depression/Anxiety	Yes	No	Father	Mother	Sister	Brother	Child(ren)	Other ___________
Tuberculosis	Yes	No	Father	Mother	Sister	Brother	Child(ren)	Other ___________
Any disorder that "runs in" your family	Yes	No						
1. Disease ___________________			Father	Mother	Sister	Brother	Child(ren)	Other ___________
2. Disease ___________________			Father	Mother	Sister	Brother	Child(ren)	Other ___________
3. Disease ___________________			Father	Mother	Sister	Brother	Child(ren)	Other ___________
4. Disease ___________________			Father	Mother	Sister	Brother	Child(ren)	Other ___________

WOMEN ONLY

Are you taking birth control pills/Depoprovera?	Yes	No
Are you pregnant or is there a possibility you may be pregnant?	Yes	No
Are you breast feeding?	Yes	No
Are you or have you passed through Menopause?	Yes	No

MISCELLANEOUS

Tobacco Use	Yes	No
If yes, what type?__________		
How much?______ How Long? ______		
Still Using Tobacco	Yes	No
Would you like to quit?	Yes	No
Quit on? (Date_______________)		
Drinking Alcholic Beverages?	Yes	No
If yes, how much? ___________		
Use(d) Methamphetamine, Amphetamines, or Speed?	Yes	No
Use(d) Intravenous Drugs?	Yes	No
Use(d) Cocaine or "Crack"?	Yes	No
Use(d) any other Recreational Drugs?	Yes	No

Patient Signature: ____________________________________ Date: _______________

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Patient Financial Agreement

I, ____________________________ (**Patient Name**), understand that services rendered to me by Cardiology & Cardiovascular Consultants are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Cardiology & Cardiovascular Consultants, and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I agree to pay in a current manner any said balance of said professional service charges over and above this insurance payment.

I understand that am responsible for any copays, coinsurance, and deductibles at the time of service. In addition, it is the responsibility for each patient to understand their insurance coverage and to verify that all appropriate referrals, or pre-authorizations required are in place before the service is rendered. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance.

I authorize the provider to release my information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of the clean claim.

I also understand that should my insurance company send payment to me, I will forward payment to Cardiology & Cardiovascular Consultants within 48 hours. I agree that if I fail to send the payment to the provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft, or other payment subject to this agreement; I will immediately deliver said check, draft, or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf, and I personally will be active in the resolution of claims delay, unjustified reductions, or denials.

Date ______________________________________ Witness ________________________________

____ ____

Signature of Policyholder/Patient Guardian Signature

PATIENT INFORMATION RELEASE

(Important – Must be updated yearly)

PATIENT'S NAME: ____________________________________ **DOB:** _________________

I, ___________________________ authorize Ron M. Roth, M.D., and Charles E. Ruggeroli, M.D. or their appointed staff to release information regarding my medical care and/or condition to the below named individual(s). This includes but is not limited to telephone conversations.

AUTHORIZED PERSON(S) AND THEIR RELATIONSHIP TO MYSELF:

____

____

____

***This release will supersede any previously signed releases and is valid until revoked by me in writing.**

____ _________________________

Patient Signature Date

____

Witness

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MEDICAL RECORDS RELEASE

Date: __________

I hereby request that my medical records be released:

To: ________________________ From: ________________________

________________________ ________________________

________________________ ________________________

Please Release the Following:

Office Notes ______ X-Rays ______ EKG ______ Labs ________

Operative Reports _______ Hospital Records ______

Diagnostic Testing _______ **All Medical Records ______**

Patient's Name ____

DOB _______________________ Social Security # __________________

Patient's Signature ____________________________

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MedRecRel_04272015

IN-OFFICE TESTING
CANCELLATION POLICY

****

If you need to cancel or reschedule an in-office test, please contact the office within 48 business hours (Monday through Friday). A patient that does not provide our office with this advance notice will be charged a late cancellation fee of $25 per test and $50 for a Nuclear Stress Test. Patients with nuclear stress tests that "no show", cancel the same day, or do not follow pre-test instructions will be charged an additional $75 to cover the cost of ordered medications specific to their test. Cancellation fees are not covered by insurance.

This cancellation policy will help serve our patients better by ensuring that testing is rescheduled with plenty of advance notice; thereby, providing the office enough time to schedule another patient requiring care in the vacant time slot.

By signing this cancellation policy, you are aware and agree to the terms of service explained above.

Patient Signature ________________________ Date _________________

Print Name _____________________________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I ___________________________________ acknowledge a copy of Cardiology & Cardiovascular Consultants' Notice of Privacy Practices has been made available to me. This notice describes how our practice may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights I may have regarding my protected health information.

Copy available upon request

____________________________________   __________________

Signature of Patient or Guardian   Date

____

Relationship if Guardian

Privacynotice_04272015

Notice To Patients Regarding The Destruction Of Health Care Records

Pursuant to NRS 629.051:

(1) Health care records of a person who is less than 23 years of age may not be destroyed; and

(2) The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law.

I have read and understand when my personal health care information may be destroyed.

______________________________ _______________

Patient Signature Date

______________________________ _______________

Witness Signature Date