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

ARDIOLOGY & ARDIOVASCULAR ONSULTANTS
The standard in patient-first, results-driven care for over 30 years.

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**

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PATIENT'S PERSONAL HISTORY

S.S. #_____ Patient No._____ Date:_____

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date	Birth Place
Address	City	State / Zip	Home Phone	Business Phone
Employer/Occupation	Medicare No.	Medicaid No.		
Insurance Company	Insurance No.			

Sex		Marital Status					Religion			
M	F	S	M	W	D	Separated	A	C	J	P

Person to Notify _____ Relationship_____

Address _____ Phone Number_____

Date of Last Physical Examination _____ Doctor _____

Family or Referring Physician _____ Address _____

FAMILY HISTORY	Sex	If Living: Age	If Living: Health	If Deceased: Age at Death	If Deceased: Cause
Father					
Mother					
Brothers/Sisters* *(Circle Sex)*					
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters* *(Circle Sex)*					
	M F				
	M F				
	M F				
	M F				
	M F				

**Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter*

Do you know of any blood relative who has or had: (Circle and give relationship)

Stroke	_____	Epilepsy	_____	Heart Attack	_____	Nervous breakdown	_____
Cancer	_____	Suicide	_____	Stomach ulcers	_____		
High blood Pressure	_____	Migraine	_____	Kidney disease	_____	Rheumatic heart	_____
Tuberculosis	_____	Asthma	_____	Goiter	_____	Insanity	_____
Diabetes	_____	Hay fever	_____	Arthritis	_____		
Leukemia	_____	Bleeding tendency	_____	Colitis	_____	Congenital heart	_____

PERSONAL HABITS: (Circle)

Yes No Do you regularly smoke? Cigarettes ☐ Pipe ☐ Cigars ☐ For how many years?

Yes No Do you usually drink over 6 cups of coffee per day?

Yes No Do you regularly drink alcohol? 1 oz. per day ☐ 2 oz. per day ☐ 4 oz. per day ☐ over 6 oz. ☐;
BEER. 1 bottle per day ☐ 2 bottles per day ☐ over 4 bottles per day ☐

Yes No Do you have difficulty in falling asleep?

Yes No Do you awaken early in the morning without apparent cause?

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MEDICATIONS:

Are you presently taking any of the following medications? (Circle)

Yes	No	Aspirin, bufferin, anacin	Yes	No	Tranquilizers
Yes	No	Blood pressure pills	Yes	No	Weight reducing pills
Yes	No	Cortisone	Yes	No	Blood thinning pills
Yes	No	Cough medicine	Yes	No	Dilantin
Yes	No	Digitalis	Yes	No	Shots
Yes	No	Hormones	Yes	No	Water pills
Yes	No	Insulin or diabetic pills	Yes	No	Antibiotics
Yes	No	Iron or poor blood medications	Yes	No	Barbituates
Yes	No	Laxatives	Yes	No	Birth control pills
Yes	No	Sleeping pills	Yes	No	Phenobarbital
Yes	No	Thyroid medicine	Yes	Nn	Other drugs not listed

Write in the names of year of any operations which you have had.

Name any drugs to which you are allergic·

Write in the names of any diseases you have had which required hospitalization.

Serious Illnesses which you have had. (not requiring hospitalization)

Serious injuries or accidents·

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To be answered by WOMEN only (Circle)

Yes	No	Are you still having regular monthly menstrual periods?	
Yes	No	Have you ever had bleeding between your periods?	When? _____
Yes	No	Do you have very heavy bleeding with your periods?	When? _____
Yes	No	Do you feel bloated and irritable before your period?	
Yes	No	Are you now on or have you ever taken the birth control pill?	When? _____
Yes	No	Have you every had a miscarriage?	When? _____
Yes	No	Have you ever had a discharge from the nipple of your breast?	When? _____
Yes	No	Do you regularly have the cancer test of the cervix?	Date of last test _____

How many children born alive _____ How many miscarriages _____
How many stillbirths _____ How many cesarean operations _____
How many premature births _____ Any complication of pregnancy _____
Date of last menstrual period _____

To be answered by men and women (Circle)

Yes	No	Do you frequently have severe headaches? (If yes, answer the following):
Yes	No	Do they cause visual trouble?
Yes	No	Do they occur on one side of the head?
Yes	No	Do they awaken you at night from sleep?
Yes	No	Do they feel like a tight hat band?
Yes	No	Do they hurt most in the back of the head and neck?
Yes	No	Does aspirine relieve them?

Yes	No	Have you ever fainted?	Yes	No	Have you ever had a convulsion?
Yes	No	Spells of dizziness?	Yes	No	Double vision?
Yes	No	Spells of weakness of an arm or leg?	Yes	No	Pains in ear*
Yes	No	Ringing in ears?	Yes	No	Nosebleeds?

Yes	No	Do you frequently have bleeding gums?	Yes	No	Do you frequently have a sore tongue?
Yes	No	Do you frequently have trouble swallowing?	Yes	No	Do you frequently have nausea and
Yes	No	Do you frequently have hoarseness?			vomiting?

Have you ever had shortness of breath?. (Circle)

Yes	No	Doing your usual work?	Yes	No	Which causes you to cough?
Yes	No	Climbing a flight of stairs?	Yes	No	Accompanied by wheezing?
Yes	No	Which awakens you at night?	Yes	No	Have you ever coughed blood?
Yes	No	Do you have a chronic cough?	Yes	No	Do you cough up much sputum?

Have you ever had chest pain or tightness in the chest which begins when. (Circle)

Yes	No	When exerting yourself?	Yes	No	Radiates down the arm?
Yes	No	When walking against a wind?	Yes	No	Disappears if you rest?
Yes	No	When walking up a hill?	Yes	No	Occurs only at rest?
Yes	No	After a heavy meal?	Yes	No	When walking fast?
Yes	No	When upset or excited?	Yes	No	When walking in cold weather?
Yes	No	Palpitations	If you have chest pain or tightness please explain. _____		
Yes	No	Do you sleep on more than one pillow?			

Have you recently had pain in the stomach which. (Circle)

Yes	No	Occurs 1 - 2 hours after a meal?
Yes	No	Is brought on by eating fried foods, gassy foods?
Yes	No	Awakens you at night?
Yes	No	Is relieved by antacid medications?
Yes	No	Is relieved with milk or eating?
Yes	No	Occurs while eating or immediately after?
Yes	No	Is relieved by a bowel movement?
Yes	No	Loss of appetite?

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If you have had a change in bowel habit recently answer the following: (Circle)			When or since when?
Yes	No	Crampy pain in the abdomen?	
Yes	No	Alternating diarrhea and constipation?	
Yes	No	Pain during or after bowel movement?	
Yes	No	Mucus in the stool?	
Yes	No	Blood in the stool?	
Yes	No	Ribbon-like stools?	
Yes	No	Black stools?	
Yes	No	Require use of strong laxatives or enemas?	
Have you had. (Circle)			
Yes	No	Burning when urinating?	
Yes	No	Loss of control of bladder?	
Yes	No	Blood in the urine?	
Yes	No	Dark colored urine?	
Yes	No	Trouble starting to urinate?	
Yes	No	Trouble holding the urine?	
Yes	No	Getting up frequently at night?	
Yes	No	Passed a kidney stone?	
Have you recently had. (Circle)			
Yes	No	Pain in calves of legs when walking?	
Yes	No	Cramps in legs at night?	
Yes	No	Pain in the big toe?	
Yes	No	Varicose veins?	
Yes	No	Phlebitis or inflamed leg veins?	
Yes	No	Swelling in the ankles?	

To be answered by MEN only: Have you ever had: (Circle)

Yes No Loss of sexual activity? For how long?_____
Yes No Treatment for genitals (private parts)?
Yes No Discharge from penis?
Yes No Hernia (rupture)?
Yes No Prostate trouble?

Describe briefly your present medical symptoms:

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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

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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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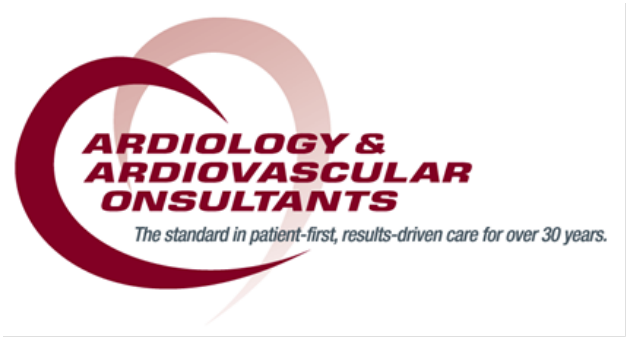

IN-OFFICE TESTING
CANCELLATION POLICY
****

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 _____

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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

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

Dstrctnotice_04272015