LONG ISLAND CARDIOVASCULAR CONSULTANTS, P.C.

1983 Marcus Ave • Suite E124 •Lake Success• NY• 11042

Welcome, **Please complete the attached enrollment forms to the best of your ability, Thank you.**

PLEASE PRINT:

PATIENT FULL NAME: _____SEX: M or F

DATE OF BIRTH: _____AGE: _____ SOCIAL SECURITY#: _____

MARITAL STATUS: (CIRCLE ONE) M D S W

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

HOME#: _____CELL#: _____

WORK#: _____EXT#_____FAX: _____

EMAIL ADDRESS: _____

EMPLOYMENT STATUS (CHECK ONE): ___EMPLOYED ___F/T STUDENT ___P/T STUDENT __OTHER

EMPLOYER NAME: _____

WORK #: _____

WORK ADDRESS: _____

PREFERRED LANGUAGE: _____

RACE: _____ETHNICITY: _____

TRANSLATOR NEEDED? YES or NO

DISABLED? YES or NO

RETIRED? YES or NO

NEXT OF KIN: _____TEL#_____

EMERGENCY CONTACT INFO:

_____

_____

_____

TEL. NO: _____

RELATIONSHIP TO PATIENT: _____

PRIMARY INSURANCE

COMPANY: _____POLICY#_____

POLICY HOLDER: SELF SPOUSE PARENT SS# OF POLICY HOLDER: _____

NAME OF POLICY HOLDER: _____DOB: _____

GROUP#: _____ NAME OF EMPLOYER: _____

SECONDARY INSURANCE

COMPANY: _____POLICY#_____

POLICY HOLDER: SELF SPOUSE PARENT SS# OF POLICY HOLDER: _____

NAME OF POLICY HOLDER: _____DOB: _____

GROUP#: _____NAME OF EMPLOYER: _____

LONG ISLAND CARDIOVASCULAR CONSULTANTS, P.C

FINANCIAL INFORMATION FOR YOUR REVIEW

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my Signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I, (Name of Insured) _____, hereby authorize (Name of Insurance Company)_____ to pay and hereby assign directly to Long Island Cardiovascular Consultants, PC all benefits if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Long Island Cardiovascular Consultants, PC will be credited to my account in accordance with the above assignment.

_____ _____

Authorized signature or subscriber **Date**

In some cases our fee for service is not covered in full by your insurance company. We want our patients to be aware of the fact that they are responsible for any balance due after the insurance payment. This balance due includes provisions set by your insurance company such as co-payments, deductibles and usual and customary allowances.

Patient's Name: _____

I understand that I am financially responsible for any charges incurred by the above named patient and I promise to pay promptly the amount of such charges that are not paid by any insurance carrier for any reason.

_____ _____

Financially Responsible Person's Signature **Date**

LONG ISLAND CARDIOVASCULAR CONSULTANTS, P.C.
PATIENT TELEPHONE LOG

Due to the importance of us relaying your test results to you we are requesting numerous telephone numbers to reach you upon emergency.
Please leave us as many numbers as you can.

YOUR NAME: _____
HOME: _____
CELL: _____
WORK: _____
SPOUSE WORK: _____
SPOUSE NAME: _____
SPOUSE CELL: _____
PARENT NAME: _____
PARENT HOME: _____
PARENT CELL: _____
ADDITIONAL: _____

I, _____, HEREBY GIVE MY PERMISSION AND AUTHORIZATION FOR LONG ISLAND CARDIOVASCULAR CONSULTANTS, P.C. TO SPEAK FREELY REGARDING MY MEDICAL HISTORY TO THE FOLLOWING PERSONS.

_____

_____

_____

_____

SIGNATURE: _____DATE:_____

Referring Doctor: _____Primary Care: _____

Reason for Visit: _____

_____

Allergies: None Known_____ Latex____ Other: _____

Please list what reaction you get: _____

<u>Past Medical History</u>: (Check all that apply)

__None ___Diabetes Type I___ Type II__ ___Hypertension ___Stroke ___Thyroid

__Respiratory Disease ___Behavioral Disorders ___Depression ___Anxiety ___Other

__Cardiovascular Disease ___AMI ___Stents ___CABG

__Cancer Breast_____ Colon_____ Prostate _____ Other_____

Have you ever been treated with ___Chemotherapy ___Radiation Therapy

<u>Past Surgical History</u>: ___None

_____

_____

_____

<u>Gynecological History</u>:

Last Mammogram_____ Last Pap Smear_____ Colonoscopy_____

Other: _____

_____

<u>Family History</u>: ____Non Applicable ____Hypertension ___Stroke ___Kidney Disease

_____ Diabetes: Type I__ Type II__ ___Cancer: Breast____ Ovarian ___Colon ___Prostate

____Other (Explain):_____

_____

<u>Social History</u>:

__None Tobacco-Current Packs/day_____ Past Hx. How many years_____Quit Date: _____

__None Alcohol-Current Amount_____ Past Hx._____Quit Date: _____

__None Current Drugs_____ Past Hx._____Quit Date: _____

History and Review cannot be obtained due to: ___Altered mental status ___Dementia __Intubated __Other:

_____

_____

REVIEW OF SYSTEM:
(CHECK ALL PERTINENT FINDINGS)

General: Chills Sweats Fatigue

Head: Headache Change in Vision Lightheadedness Dizziness

Neck: Lumps Difficulty Swallowing Change in Voice

Cardiac: Chest Pain Shortness of Breath Palpitations Irregular Heart Beat Arrhythmia

Respiratory: Cough: Chronic or Acute Wheezing

Eating Disorders Weight Loss Nausea Vomiting Heartburn

GI: Constipation Abdominal Pain Acid Reflux

GU: Blood in Urine Painful Urination Frequent/Urgent Urination

Musculoskeletal: Back Pain Bone Pain Joint Pain Joint Swelling

Neurological: Numbness Tingling Weakness Difficulty Walking Seizures

Psychological: Anxiety Depression Insomnia

Endocrine: Thirst Unexplained Weight Loss/Gain Fatigue

Lymphatic: Swollen Glands

Hematologic: Abnormal Bleeding

Are you currently experiencing pain? _____

If so, on a scale of 1-10, please rate your pain (10 being the most severe)

Functional Assessment: ___No need

____Walk independently ___Wheelchair Bound ___Walks with Assistance

MEDICATION WORKSHEET

NAME: _____ DOB: _____

ALLERGIES

PHARMACY NAME: _____
PHARMACY ADDRESS: _____
PHARMACY NUMBER: _____

PHARMACY NAME: _____
PHARMACY ADDRESS: _____
PHARMACY NUMBER: _____

CURRENT MEDICATIONS

DATE	DRUG	DOSAGE	FREQUENCY	DISPENSED

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, authorize ***Long Island Cardiovascular Consultants, PC*** to discuss my health information with the following personal representative(s). These representatives must provide the following PASSCODE that I have selected prior to discussing my health information:

PASSCODE: _____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

It is the policy of **Long Island Cardiovascular Consultants, PC** to confirm appointments via telephone or in some cases with an automated appointment confirmation service.

I wish to be contacted in the following manner (Check all that apply)

Home#:_____ **Cell#:_____**

☐ OK to leave message with detailed information* ☐ OK to leave message with detailed information*

☐ Leave message with call back number only ☐ Leave message with call back number only

Written Communication **Work Telephone: _____**

☐ OK to mail to my home address ☐ OK to leave message with detailed information*

☐ OK to mail to my work/office address ☐ Leave message with call back number only

Work Address: _____

☐ OK to fax to this number: _____

Other: _____

Patient Full Name: _____DOB:_____

_____ _____

Patient Signature **Date**

***detailed information may include but is not limited to: lab results, diagnosis, treatment instructions**

PLEASE NOTE, THE ABOVE INFORMATION WILL BE IN EFFECT UNTIL YOU REVOKE IT.

LONG ISLAND CARDIOVASCULAR CONSULTANTS, P.C.

I HAVE READ AND UNDERSTAND THE OFFICE'S PATIENT BILL OF RIGHTS, SAFETY STATEMENTS, HIPPA AGREEMENT.

_____	_____	_____
PRINT PATIENT NAME	**DATE**	**DOB**

_____	_____
PATIENT SIGNATURE	**DATE**

Kenneth H. Cohen, M.D., FACC
Ronald D'Agostino, D.O., FACC
Henry E. Gomez, M.D., FACC
Gregory Ackert, M.D.
James Hess, D.O.

Dear Patient:

Exciting news!!! We will be implementing a Healthcare Support Portal. The patient portal is a web-based service that gives you secure access to parts of your electronic medical record. You can also communicate with your LICC physician's office online about non-urgent medical issues and administrative issues.

The patient portal offers many features to help you manage your personal health information at your convenience:

- Update personal information
- Exchange secure messages with your Doctor's office
- View upcoming appointments
- Fill out forms
- Request a prescription refill
- View account statements
- Provides patients with a clinical summary after each visit

This is just a short list of options that will be available to you.

All communication on the Patient Portal between you and your Doctor's office use a secure, encrypted connection.

INTERESTED?? Just give us your e-mail address and information will be sent to you on how to set up your access.

Patient Name: _____
Email Address: _____
Any questions, feel free to ask
Have a Great Day!!!!