CARDIOVASCULAR SPECIALISTS

DAVE GILBERT DO
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PATIENT REGISTRATION FORM:

Today's Date:_____

Patient Name: _____

Age:_____ Date of Birth:_____

Social Security #:_____

Sex: Male Female

Billing Address:_____
Street / P.O. City State Zip

Home Phone:_____ Cell Phone:_____

Work Phone_____

Email Address:_____

Race: White African American Hispanic Asian Other

Employment: Retired Full- Time Part-Time Unemployed Self Employed Military Homemaker

Primary Language: English Other:_____

Marital status:
Single Married Male Partner Female Partner Separated Divorced Widowed Never Married

Insured's Employer:_____
Contact Person:_____
Office Phone:_____
Employer Address:_____

Guarantor/ Legal Guardian Information

Emergency Contact Name:_____
Relationship:_____
Primary Phone:_____
Address:_____
Secondary Phone:_____

Power of Attorney Name:_____
Phone:_____

Pharmacy Information
Pharmacy Name:_____

Pharmacy Phone #:_____
Pharmacy Address:_____

Insurance Information

Primary Insurance_____

Secondary Insurance_____

Primary Insurance Name:_____
Address: _____
City _____ State _____ Zip _____
Phone No: _____ Fax No: _____
Member ID#: _____Group #:_____
Insured Name: _____
Relationship: _____
SSN#:_____ DOB: _____
INSURANCE COPAY: _____ DEDUCTIBLE: _____

Secondary Ins Name:_____
Address: _____
City _____ State _____ Zip _____
Phone No: _____ Fax No: _____
Member ID#: _____Group #:_____
Insured Name: _____
Relationship: _____
SSN#:_____ DOB: _____
INSURANCE COPAY: _____ DEDUCTIBLE: _____

What is the main reason for your Cardiology visit? _____

_____

_____

What symptoms are you currently having? _____

_____

LIST OF CURRENT MEDICATIONS AND DOSAGE:_____

_____

_____

LIST OF ALLERGIES AND REACTIONS: _____

_____

ANY ALLERGY TO IODINE DYE: _____

Check all that apply

S.N 0.	Past Medical History	Yes	No
1.	Coronary Artery Disease		
2.	Heart Attack		
3.	Angioplasty or Stent of Heart Arteries		
4.	Coronary Artery Bypass		
5.	Peripheral Vascular Disease (PAD or PVD)		
6.	Angioplasty or Stent of Leg Arteries		
7.	Carotid Stenosis (Blockage)		
8.	Carotid Artery Surgery or Stent		
9.	Abdominal Aortic Aneurysm		
10.	Stroke		
11.	Atrial Fibrillation or Atrial Flutter		
12.	Diabetes		
13.	High Cholesterol		
14.	High Blood Pressure		
15.	Pacemaker Placement		
16.	Defibrillator Placement		
17.	Congestive Heart Failure		
18.	Asthma		
19.	COPD		

Check all that apply		YES	NO
20.	Blood Clots in Lungs (Pulmonary Embolism)		
21.	Blood Clots of Leg Veins (DVT)		
22.	Thyroid Abnormalities		
23.	Any other significant Medical or Surgical History		

Check all that apply

Family History	Yes	Relationship	No	Unknown
Heart Attack				
Heart Stent or Bypass Surgery				
Sudden Cardiac Death				
Stroke				
Carotid Artery Surgery				
Congestive Heart Failure				
Pacemaker Placement				
Cancer				

Social History:

Are you married? _____

Do you currently smoke? _____ How many cigarettes/day?_____

Have you ever been a smoker?_____

How many/day? _____ How long?_____

Do you use recreational drugs? _____

Occupation:_____

Patient Name (print name):_____

It is our goal to provide you and your family the very best service possible. As a service to our patients we are participating in a large number of health plans, thereby making our services accessible to as many patients as possible. Please understand that in order to continue to provide outstanding services to our patients we need to maintain our administrative cost to a minimum.
Hereto is a summary of our financial and billing policies to identify clearly our processes, whereby your signature below acknowledges understanding of our financial policies outlined below:

1)FILED CLAIMS: the office will file all claims for services rendered to primary and secondary insurances. It is the patient's responsibility to furnish accurate, complete and current insurance information.

2)PAYMENTS: we file secondary insurance claims for all our patients. However, in many cases secondary insurances will pay patients directly or your insurance policy has deductibles, coinsurances or similar provisions that will result in a non-payment for balances after your primary insurance has paid a claim. We reserve the right to bill any unpaid balances directly to the patient if no payment from a secondary insurance is received within 60 days after filing. These balances are due in full from the patient at the time of statement receipt.

3)BILLING: questions regarding the billing process, charges on your account or to update or change information have to be addressed to the office in charge of the Billing Department. Inquiries via phone should be directed to our office at 717-814-5052, to avoid delays in processing.

4)INSURANCE CO-PAYS: Because of the variety of different plans and contracts insurances have and the constant changes within each plan, we

cannot be held responsible for the accuracy of co-payments collected. In rare cases we have discrepancies between collected amounts and the amounts your insurance contract requires. Adjustments of this nature will be made at the time the insurance notification is received and either credited to the patient's account or billed to the patient.

5)COLLECTIONS: We try to work with patients to find ways to make the payment process as easy as possible. However, if we do not receive payment after the stated grace period, accounts may be evaluated for further collection process and the office may consider discharging a patient from the practice for non-payment(s).
We sincerely hope these policies promote our overall goal of transparency and team-oriented health care. Please feel free to let us know if there are any items we can improve to make the administrative side of our practice as painless and easy for you as possible.

PATIENT ACKNOWLEDGEMENT
By my signature below, I acknowledge to have read the above policies and agree to the terms out lines. I understand my responsibilities and the consequences for violation of the financial responsibilities. I was given the opportunity to ask questions regarding the financial policies and understand their impact on my relationship to the practice.

Patient Signature:_____Date:_____

AUTHORIZATION FOR TREATMENT:

Patient Name (print name):_____

I, the undersigned, hereby voluntarily consent to medical care / diagnostic treatment and/or minor surgical treatment by Advanced Heart and Vascular Associates deemed advisable and necessary in the diagnosis and treatment of my condition.
I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.
I authorize the release of any past/current medical records that are needed for my treatment from any prior healthcare providers and for information.

Patient Signature:_____

Date:_____

Witness Signature:_____

Date: _____