Advanced Heart and Vascular Center of NM

Amanda Ryan, DO * Jennifer Tupper, DNP, APRN, FNP-BC * Missy Richardson, MSN, FNP-C

New Patient Registration

Registration Date: _____ Account Number: _____

Patient Names (**Legal**): _____

Gender: _____ Marital Status: _____ Race: _____

Patient Social Security #: _____ DOB: _____

Patient Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Cell: _____ Work: _____

Email: _____ **Register with the Patient Portal: Yes / No**

For registration for our patient portal, please ask our reception team to get you access.

Primary Care Doctor: _____ Hospital Preference: _____

Preferred Lab: _____ Pharmacy: _____

Reason for Service: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

GUARANTOR INFORMATION

IS THIS PERSON THE PRIMARY INSURED PERSON? Yes / No

Guarantor Name: _____ Phone: _____

Address: _____ City, State: _____ Zip: _____

Relationship to patient: _____ Guarantor DOB: _____

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Please ensure that all your insurance information is written in the proper order to eliminate any billing issues. We also ask that you bring your insurance cards at the time of your appointment. Thank you!

PRIMARY INSURANCE

INSURANCE NAME: _____

NAME OF INSURED: _____ DOB: _____

POLICY ID: _____ GROUP NUMBER: _____

INSURANCE CONTACT NUMBER: _____

SECONDARY INSURANCE

INSURANCE NAME: _____

NAME OF INSURED: _____ DOB: _____

POLICY ID: _____ GROUP NUMBER: _____

INSURANCE CONTACT NUMBER: _____

☐ *BY CHECKING THIS BOX, THIS IS AN ACKNOWLEDGMENT THAT ALL INSURANCE INFORMATION HAS BEEN PROVIDED IN THE CORRECT BILLING ORDER.*

EMPLOYMENT

EMPLOYER NAME: _____ EMPLOYMENT RELATED: Yes / No

Our physicians conduct routine follow up calls concerning your visits. Do you consent for us to contact you in order to see how things went with you visit? Y/N If yes, how would you prefer we contact you? Phone/ Text/ Email

_____ _____

Patient/Guardian Signature **Date**

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Request for Confidential Communication of Protected Health Information

I, _____ request communication of my protected health information (PHI) for Advance Heart and Vascular Center of NM, alternative means or at alternative locations. I understand this request applies only to communications from Advance Heart and Vascular Center of NM to the patient, and communications that would be sent to the named insured of an insurance policy that covers the patient as a dependent of the named insured.

Please indicate methods and/or locations by or at which we may contact you.

Telephone work/cell/home: _____

Mailing Address: _____City, State: _____ Zip: _____

Email Address: _____

Other: _____

OTHER PARTIES THAT WE MY RELAY YOUR PROTECTED HEALTH INFORMATION:

Name: _____ Relationship to Patient: _____

Patient DOB: _____ Patient SSN: _____

***NOTE**: This request will remain in effect until you notify us of a change.*

_____ _____

Printed Name **Date**

_____ _____

Signature **Date**

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ADVANCED HEART AND VASCULAR CENTER OF NEW MEXICO
ACKNOWLEDGMENT OF TREATMENT

Do you have an Advance Directive or a Living Will? Yes / No

- **Authorization for Treatment:**

I_____Hereby authorize Advanced Heart and Vascular Center of NM to provide medical care and treatment that is deemed medically necessary.

_____ _____

Signature **Date**

- **Assignment of Benefits and Disclosure of Information**:

I, _____ hereby authorize payment directly to Advanced Heart and Vascular Center of NM. I also authorize the release of any medical record information for insurance.

_____ _____

Signature **Date**

- **Notice of Privacy Practice:**

I, _____ have received the Notice of Privacy Practice. Your signature indicates that you understand and have received a copy of your notice.

_____ _____

Signature **Date**

- **Parent/Guardian**

If in the event that my spouse or myself are not available; I, _____ give permission for Advanced Heart and Vascular Center of NM to provide medical care and treatment to my child(ren) if they deem it medically necessary. While my child(ren) is under the supervision of:

_____ _____

Name **Relationship to patient**

_____ _____

Signature **Date**

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ADVANCED HEART AND VASCULAR CENTER OF NEW MEXICO
FINANCIAL POLICY

I, _____ acknowledge that my insurance policy is a contract between my insurance and myself. It is your responsibility to know what type of coverage you have for services.

We will bill your insurance company, but we cannot guarantee benefits or amounts. We do have discounts; payment plans and will work the best we can to ensure you receive quality medical care treatment at a cost-effective approach.

You are responsible for the balance **at the time of your visit**, and balances thereafter will be due within 30 days from time of service.

For payment options or arraignments please contact our office.

Insurance deductibles and co-payments are due at the time of service. Adults accompanying a minor are responsible for the payment of service.

Questions about this policy statement or method of payment can be directed to our billing team, please contact our office.

_____ _____

Printed Name **Date**

_____ _____

Signature **Date**

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Name: _____ Age: _____ Date: _____

Primary Care Doctor(s)_____

What problem brought you to this office? _____

Pharmacy: _____

GENERAL INFORMATION

Have you ever had any of the following problems?

_____	Chest Pain	_____	Rheumatic Fever	_____	Heart Attack
_____	Shortness of Breath	_____	Heart Murmur	_____	Abnormal Heartbeat
_____	Heart Failure	_____	Stroke	_____	Blood Clots
_____	Enlarged Heart	_____	Abnormal EKG	_____	Leg Pain

RISK FACTORS FOR HEART DISEASE

Cigarettes	1. Do you smoke cigarettes? _____ 2. Use other tobacco? _____ 3. How many did/do you smoke per day? _____ 4. For how many years? _____
Blood Pressure	5. Do you have high blood pressure? _____ 6. If yes, for how many years? _____ 7. How many years have you been treated for high blood pressure? _____
Lipids	8. Have you ever been told you have an abnormal: 9. Cholesterol? _____ Triglycerides? _____ HDL? _____ 10. Do you know the numbers? _____ 11. Are you on a low-fat diet? Yes ____ No _____
Diabetes	12. Do you have diabetes? _____ Type: _____ How long? _____ 13. What Treatment? Diet: _____ Insulin: _____ Drugs: _____
Family History	14. Do you have a family history of heart attacks or sudden death? _____ 15. Mother: _____ Father: _____ Brothers: _____ Sisters: _____
Exercise	16. How much exercise do you get? 17. No regular exercise program _____ B) Irregular Exercise _____ 18. Regular exercise (List what you do) _____
Menopause	19. Have you gone through menopause? _____ 20. Are you currently receiving hormone replacement therapy? _____
Weight	21. What is your highest and lowest adult weight? _____ / _____ 22. Present weight? _____

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Personality	23. What is your personality type? Tense: _____ Relaxed: _____ Average: _____
Stress	24. Have there been any stresses in your life that may be contributing to your problems? _____

LIST YOUR MEDICINES

NAME OF MEDICINE	MG	TIMES A DAY

PERSONAL HISTORY

Allergies/List: _____

_____

Do you consume alcohol at all? _____

How many drinks a day (average)? _____ How many beers a day? _____ Did you ever drink more? _____

How much coffee do you drink a day? Decaffeinated _____

Less than 2 cups: ____ 2-5 cups: _____ More than 5 cups? _____

Are you employed outside the home? _____ Retired? ____

Describe your position: _____

_____

_____

If you are retired, how do you spend your time? _____

_____

_____

_____

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PREVIOUS HISTORY

TYPE OF OPERATION	DATE

PAST MEDICAL HISTORY

Have you been in the hospital for any serious illness? _____

Problem:

1) _____

2) _____

3) _____

FAMILY HISTORY (do not list names)

FAMILY MEMBER	Age	Alive (yes/no)	Age at death	Cause of death
FATHER				
MOTHER				

Did any family member: mother, father, brother, sister – have any of the following:

	WHO HAD IT	HOW OLD WERE THEY WHEN
STROKE		
HEART ATTACK		
HYPERTENSION		
DIABETES		
ABNORMAL BLOOD FATS		

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REVIEW OF YOUR GENERAL MEDICAL HISTORY

CHECK ANY OF THE PROBLEMS THAT YOU HAVE OR HAD IN THE PAST:

PROBLEMS	SYMPTOMS	NOW	PAST
GENERAL:	1. Weight loss of more than 5lbs in the past six months	_____	_____
	2. Undue tiredness	_____	_____
	3. Poor appetite	_____	_____
EYES AND EARS:	4. Double vision	_____	_____
	5. Loss of vision (even brief)	_____	_____
	6. Difficulty hearing	_____	_____
MOUTH:	7. Gum or teeth problems	_____	_____
PULMONARY:	8. Cough	_____	_____
	9. Coughed up any blood	_____	_____
	10. Recurrent chest infections	_____	_____
GASTRO-INTESTINAL:	11. History of ulcer	_____	_____
	12. Hiatal hernia	_____	_____
	13. Burning in pit of stomach between meals or at night	_____	_____
	14. Liver disease	_____	_____
	15. Constipation or diarrhea	_____	_____
	16. Rectal bleeding or black tarry stools	_____	_____
GENITOURINARY:	17. Kidney or bladder infections	_____	_____
	18. Frequent urination	_____	_____
	19. Get up at night to urinate	_____	_____
	20. Difficulty starting or stopping your stream	_____	_____
EXTREMITIES:	21. Varicose Veins	_____	_____
	22. Phlebitis	_____	_____
	23. Leg pain	_____	_____
NEUROLOGICAL:	24. Stroke	_____	_____
	25. Frequent headaches	_____	_____
	26. Paralysis of any part of your body	_____	_____
	27. Not being able to talk distinctly	_____	_____
	28. Seizure	_____	_____
ENDOCRINE:	29. Thyroid trouble	_____	_____
	30. [Women] are your menses (periods) normal?	_____	_____
	31. Do you feel hot more often than other people?	_____	_____
HEMATOLOGY:	32. Have you ever received a transfusion?	_____	_____
	33. Do you bleed a lot with cuts?	_____	_____
	34. Have you ever been anemic?	_____	_____
	35. Have you ever been told you have a bleeding problem?	_____	_____
PSYCHIATRIC:	36. Have you ever seen a psychiatrist?	_____	_____
OB-GYN:	37. Birth control pills or hormone supplement	_____	_____