



Andrew D. Forbes, M.D., F.A.C.S.  
Jeffrey J. Gilbertson, M.D., F.A.C.S.  
S. Scott Huerd, M.D., F.A.C.S.  
Philippe A. Masser, M.D.  
Brian D. Matteson, M.D., F.A.C.S.  
David C. Stuesse, M.D.  
Michael J. Tullis, M.D., F.A.C.S.

Dear Patient:

Welcome to Cardiothoracic & Vascular Associates. You have been scheduled for an appointment with one of our physicians in either our office downtown at 333 N. 1<sup>st</sup> St. #280, Boise, ID 83702 or in Meridian at 977 S. Progress Way, Meridian, ID 83642. If you are unsure of your appointment time, date or location, please contact our office by phone at (208) 345-6545.

In an effort to expedite the time you will spend in our office, please complete the following forms prior to your scheduled appointment. In an effort to avoid confusion and duplication of records, we ask that you complete the attached information sheets with your full legal name. If you use a different name other than the one on your insurance card, please inform us. Also, if your legal name is hyphenated, please use it each time you contact our office.

The following items will be needed for your initial appointment:

1. Patient Information and Consent Sheet.
2. Patient Health History Exam Form (*fully completed*). If there is not enough room on the form, please attach a separate list of allergies, medications (include dosage amount and frequency) and/or your medical and surgical history, if necessary.
3. Authorization to Release Medical Records (*fully completed*)
4. All insurance cards (*primary and all secondary coverages*)
5. Picture identification card

If you have other questions about the forms or about your scheduled appointment, please call (208) 345-6545. If you are unable to keep your scheduled appointment, please call to cancel or reschedule.

Thank you.

The Staff at Cardiothoracic & Vascular Associates

Phone 208-345-6545 Fax 208-345-1213 Billing 208-342-1108 333 North 1st Street, Suite 280 Boise, Idaho 83702

CVA is an affiliate of Cardiovascular & Chest Surgical Associates, P.A.  
[www.cardvasc.com](http://www.cardvasc.com)

**Cardiothoracic & Vascular Associates**  
**PATIENT INFORMATION AND CONSENT**

Date \_\_\_\_\_ Doctor \_\_\_\_\_ Account # \_\_\_\_\_

Last Name \_\_\_\_\_

Sex \_\_\_\_\_ (M)ale (F)emale

First Name \_\_\_\_\_

Marital Status: Single Married Divorced

Address \_\_\_\_\_

Separated Widow Minor

Employer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family Physician \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Referring Physician \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Other Physician to Contact \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_

E-mail \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_

If married, Spouse's Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Spouse's DOB \_\_\_\_\_ SS# \_\_\_\_\_

Age \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**BILLING INFORMATION**

Do you have medical insurance? Yes No

**PRIMARY INSURANCE COMPANY**

**SECONDARY INSURANCE COMPANY**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

ID # \_\_\_\_\_

ID # \_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

Subscriber \_\_\_\_\_

Subscriber \_\_\_\_\_

Birth Date \_\_\_\_\_

Birth Date \_\_\_\_\_

Social Security # \_\_\_\_\_

Social Security # \_\_\_\_\_

Responsible Party \_\_\_\_\_

Phone \_\_\_\_\_

As patient or legal guardian of patient, I agree to be fully responsible for all charges for services rendered. I authorize my doctor or his agent to submit claims to Medicare or my insurance carriers for charges incurred. I authorize my Medicare or insurance benefits to be paid directly to the doctor. I understand that there is a possibility of non-coverage by my insurance companies or Medicare. If they determine that any service is deemed "medically unnecessary", I agree to assume responsibility for denied payment. I further authorize this office to obtain and release my medical records to and from other physicians, medical facilities, insurance companies and Medicare to facilitate my health care and appropriate payments.

Do you authorize release of your medical information to anyone besides your insurance carrier?  Yes  No If so, whom? \_\_\_\_\_

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_



**Welcome to our Practice  
MEDICAL HISTORY FORM**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Chief Complaint:** (Main reason for visit) \_\_\_\_\_

**Allergies:** If none, please check this box

Drug	Reaction	Drug	Reaction
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Have you been told you are allergic to latex?  Yes  No

**Medications:** (What medicine are you currently taking?)

Name of Drug	Dosage	Frequency	Name of Drug	Dosage	Frequency
1. _____	_____	_____	6. _____	_____	_____
2. _____	_____	_____	7. _____	_____	_____
3. _____	_____	_____	8. _____	_____	_____
4. _____	_____	_____	9. _____	_____	_____
5. _____	_____	_____	10. _____	_____	_____

**Circle if taking:** Aspirin Plavix Coumadin Herbal

**Past Medical History:** (Please check any you have now or have had in the past)

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Acid Reflux       | <input type="checkbox"/> Depression    | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> History of Blood Clots | <input type="checkbox"/> Stroke         |

**Additional Illnesses:**

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

**Past Surgical History:** (What operations have you had?)

Operation	Year	Operation	Year
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

**Family History:** (Do any diseases or medical problems run in your family; i.e. high blood pressure, heart disease, stroke, diabetes, blood clots, cancer, anesthetic problems, etc?)

Problems/Disease	Family member affected	Problems/Disease	Family member affected
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

**Social History:**

Have you ever smoked?  Yes  No      Quit?  Yes  No      When? \_\_\_\_\_  
If you have smoked, how many packs per day? \_\_\_\_\_ For how many years \_\_\_\_\_

Do you drink alcohol?  Yes  No  
How many beers in a week? \_\_\_\_\_ Glasses of wine per week? \_\_\_\_\_ Mixed drinks per week? \_\_\_\_\_

Recreational Drug Use?  Yes  No

Current Employment: \_\_\_\_\_

If retired, what kind of work did you do? \_\_\_\_\_

**Review of Systems:** (Please check all that apply)**General**

- Night sweats
- Chills
- Recent weight change
- Appetite loss
- Fevers
- Fatigue

**Eyes**

- Glaucoma
- Vision loss - one eye
- Vision loss - both eyes

**Ears/Nose/Mouth/Throat**

- Hearing loss
- Hoarseness
- Difficulty swallowing
- Nosebleeds

**Endocrine**

- Excessive thirst or urination
- Heat or cold intolerance
- Thyroid problem

**Neurologic**

- Frequent or recurring headaches
- Lightheaded or dizzy
- Convulsions or seizures
- Numbness or weakness
- Tremors
- Head injuries

**Respiratory**

- Chronic cough
- Spitting up blood
- Shortness of breath at rest
- Wheezing
- Excessive snoring
- History of tuberculosis

**Cardiovascular**

- Heart murmur
- Chest Pain or Discomfort
- Palpitations
- Shortness of breath  
when walking or lying flat
- Swelling of feet, ankles  
or hands
- Leg cramps with exertion
- Difficulty breathing
- Racing/skipping heart beats

**Gastrointestinal**

- Pain with eating
- Bowel changes
- Nausea and/or vomiting
- Diarrhea
- History of Jaundice
- Heartburn
- Rectal bleeding or blood  
in stool
- Dark tarry stools

**Skin**

- Poor wound healing
- Skin cancer

**Musculoskeletal**

- Muscle pain or cramps
- Gout
- Arthritis

**Psychiatric**

- Anxiety
- Depression
- Memory loss or confusion

**Blood/Lymphatic**

- Bleeding tendency
- Enlarged lymph nodes

**Allergic/Immunologic**

- HIV exposure
- Hives or rash
- Seasonal allergies

**Genitourinary**

- Frequent Urination
- Blood in urine
- History of kidney stones
- Erectile dysfunction
- Inability to empty bladder
- Painful urination
- Night time urination
- Inability to control bladder
- Trouble starting urinary  
stream

**CARDIOTHORACIC & VASCULAR ASSOCIATES**

**Authorization to Release Medical Records**

*(Please read carefully)*

Since HIPAA legislation became effective in April of 2003, we are no longer allowed to automatically assume that our patients authorize us to give out information about their care to anyone other than themselves—not even to immediate family members or close friends. For that reason, please list the names of all family members, friends, organizations, etc. that you give us permission to release information to about your care. If anyone not listed on this form calls or otherwise asks us for information about you (even for information as basic as when your next appointment is or how you are doing in surgical follow up), we will have to refuse to give them that information until we get your expressed permission to do so. Please do not list here your primary care doctor, the doctor who referred you to us or your medical insurance(s), as these people automatically have access to your information kept at this office.

The following persons are allowed to have information about my care at CVA.

(Please list all that apply)

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(Name) (Relationship) (Phone #)

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(Name) (Relationship) (Phone #)

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(Name) (Relationship) (Phone #)

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(Name) (Relationship) (Phone #)

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(Name) (Relationship) (Phone #)

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(Name) (Relationship) (Phone #)

---

(Name) (Relationship) (Phone #)

---

(Name) (Relationship) (Phone #)

---

Patient Name (Print)

---

Patient or Guardian signature

---

Date

# CARDIOTHORACIC & VASCULAR ASSOCIATES

## FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient:

Thank you for choosing the physicians at Cardiothoracic & Vascular Associates as your healthcare provider. We appreciate the opportunity to provide you with professional specialized care.

The following is our financial policy. We believe having financial matters clear from the onset is preferable to encountering difficulties later on. If you have any questions or concerns about our payment policies, please do not hesitate to talk with our billing department.

Payment for services is due at the time service is rendered. We accept cash, checks, debit cards, MasterCard, Visa and Discover. We will submit an insurance claim on your behalf if we have all your insurance information. If your insurance carrier changes, please notify the Billing Department immediately.

You must understand the following:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you—not your insurance company. Please make sure our receptionist has all of your correct information on file when you sign in at each visit.
2. Prior to your surgery you will meet with our patient representative to review your surgical charges. Please understand this is only an estimate and your procedure could change once the physician begins the surgery. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles, coinsurance and co-payments, are due at the time of treatment.
3. You are responsible for knowing your insurance benefits. Does your insurance require a referral? Do our physicians participate in your plan? What facilities participate in your plan? If we can be of any assistance, please let us know and we will be happy to help you.
4. Accounts not paid within 90 days may be forwarded to a billing company where additional fees may be accrued.
5. CVA reserves the right to charge a \$20 service fee for checks returned due to insufficient funds.
6. If you have inadequate or no insurance coverage, advance planning for payment before surgery will be required. The fee for surgery will normally include your postoperative office visits for a period up to 90 days.
7. You are responsible for any and all collection fees, legal fees and court costs associated with efforts to collect payment on your account.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems with our Billing Department so that we can assist you in the management of your account.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature