

**ST. LUKE'S CLINIC - 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

City _____ State _____ Zip _____

Employer _____

Home Phone () _____

Family Physician _____

Work Phone () _____

Referring Physician _____

Cell Phone () _____

Other Physician to Contact _____

E-mail _____

Emergency Contact _____

Date of Birth _____

Relationship _____ Phone _____

Social Security # _____

If married, Spouse's Name _____

Age _____

Spouse's DOB _____ SS# _____

How did you hear about us? _____

BILLING INFORMATION

Do you have medical insurance? Yes No

PRIMARY INSURANCE COMPANY

Name _____

Address _____

ID # _____

Group # _____

Subscriber _____

Birth Date _____

Social Security # _____

Responsible Party _____

SECONDARY INSURANCE COMPANY

Name _____

Address _____

ID # _____

Group # _____

Subscriber _____

Birth Date _____

Social Security # _____

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
- Sores in mouth

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
- Loss of coordination
- Poor balance
- Inability to speak
- Fainting
- Sudden vision loss

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
- Abnormal cholesterol level

Gastrointestinal

- Indigestion
- Change in bowel habits
- Nausea and/or vomiting
- Diarrhea
- History of Jaundice
- Heartburn
- Rectal bleeding
- Blood in stool
- Dark tarry stools
- Ulcers
- Constipation
- Yellow skin color
- Vomited blood
- Abdominal pain

Musculoskeletal

- Muscle pain or cramps
- Gout
- Arthritis
- Joint swelling

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 empty bladder
- Trouble starting urinary stream

Skin

- Poor wound healing
- Changing moles
- Skin cancer

Do you feel safe in your home environment Yes No

What is your preference for learning? (circle one) Verbal Visual Auditory Demonstration

What is your language preference? (circle one) English Spanish Other _____

ST. LUKE'S CLINIC - 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 St. Luke's CVA.
(Please list all that apply)

(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

Patient Name (Print)

Patient or Guardian signature

Date

ST. LUKE'S CARDIOTHORACIC & VASCULAR ASSOCIATES
Financial Policy and Patient Responsibility

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 financial department.

Co-payments, co-insurance and/or deductibles are due at the time services are rendered. As an added convenience to you we accept cash, checks, debit cards, MasterCard, Visa, Discover and American Express. We 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 check in at **each visit**.
2. As a St. Luke's clinic we are required to file two claims to your insurance. Therefore, you will be receiving two bills – one from St. Luke's for the facility portion and one from SLCVA for the physician's portion. As the beneficiary, your insurance requires you to make a coinsurance payment for the facility services and the professional services. Your coinsurance amount will depend on the actual services you receive.
3. SLCVA reserves the right to charge a \$20 service fee for checks returned due to insufficient funds.

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.

For questions about your bill, please call:

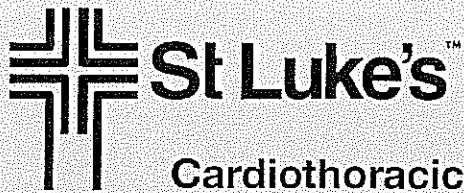
| | |
|--|--------------|
| Professional Fee – St. Luke's Cardiothoracic and Vascular Associates | 208.342.1108 |
| Facility Fee – St. Luke's Regional Medical Center | 208.706.2333 |

I have read and understand the above financial policy. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

Patient Signature

Date: _____

Print Patient Name



St Luke's™

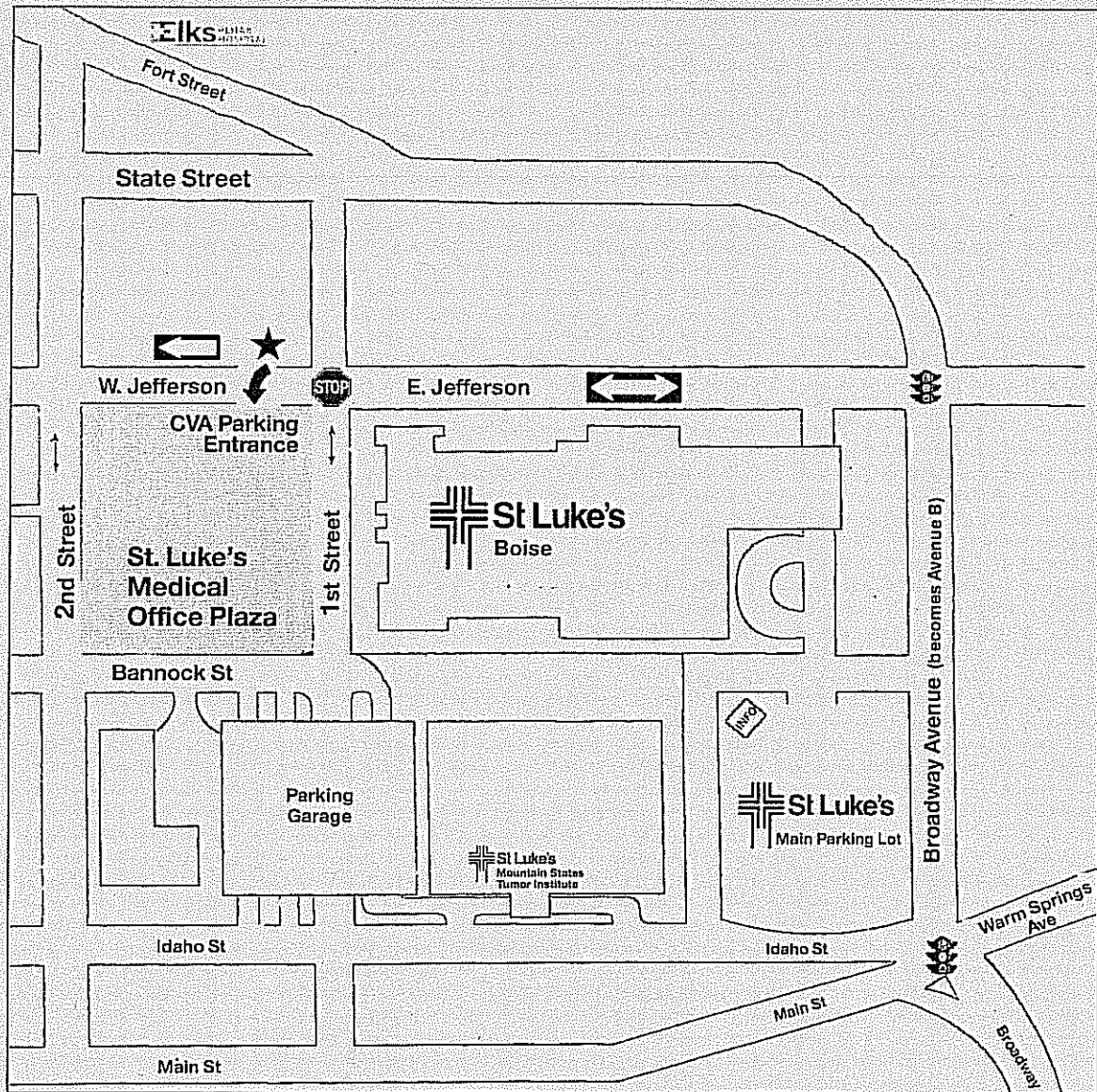
**Cardiothoracic &
Vascular Associates**

333 N. 1st Street, Suite 280

Boise, ID 83702

208-345-6545

We are located in the **St. Luke's Medical Office Plaza** at the corner of 1st and Jefferson St in downtown Boise just west of St. Luke's Boise Medical Center. Free parking is available within the parking garage of our building - Enter off of Jefferson St.



Directions:

From the West, take City Center exit (I-184) to Broadway and turn left. Continue on Broadway to Jefferson and turn left. Cross 1st Street and enter the SLMOP parking garage on the left side of Jefferson.

You may drive to the second level for the closet parking to our office.

From the East, take Broadway exit. Go north on Broadway to Jefferson Street and turn left. Cross 1st Street and enter the SLMOP parking garage on the left side of Jefferson.

You may drive to the second level for the closet parking to our office.