CARDIOVASCULAR HEALTH QUESTIONNAIRE

Today's Date: _____

Name: _____ Date of Birth: _____

Family Physician: _____ Smoking History: _____

Occupation: _____

Drug Allergies: (list medications and symptoms caused): _____

_____

Please list current medications, including any vitamins & supplements:

Previous Surgery: (list operations and dates)

Family History:	Living	Deceased	Cause of Death	Illnesses
Father	○	○		
Mother	○	○		
Brothers	0	0		
Sisters	0	0		

Do you have any of the following?	Yes	No	If yes, for how long?
Chest Pain	○	○	Chest pain at rest: _____ or with exercise: _____
Shortness of Breath	○	○	
Diabetes (or abnormal blood sugar)	○	○	
Increased or abnormal blood pressure	○	○	
Swelling of the Legs or Feet	○	○	
Pain in the Calves when Walking	○	○	
Heart Murmur	○	○	
History of Rheumatic Fever	○	○	
Palpitations (skipped heart beats or "rapid heart action")	○	○	
Passing out or Black-out Spells	○	○	
Have you ever had a "Heart Attack"?	○	○	
Have you ever been told you had an "Abnormal EKG"?	○	○	
History of Lung Disease	○	○	
History of Bleeding Disorder or Internal Bleeding	○	○	

Do you have an inserted device like an ICD, pacemaker or defibrillator? If so, please indicate brand:

○ St. Jude ○ Medtronic
○ Boston Scientific ○ Biotronic
Other (or unknown): _____

What single complaint bothers you the most?
(Please use reverse side or below if more room is needed)

_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

I authorize my health care provider (Name)_____

To release my health care information to:
AMS Cardiology Attn: Dr. _____
118 Welsh Road
Unit B
Horsham, PA 19044
Fax#: 215-376-1705

I authorize the release of the following health information:

___Office notes, hospital summaries, test results

___Communication from other physicians/consultants

___List any specific items to be sent that are not covered above:

_____

I understand that I may revoke this authorization/consent (except to the extent that action has been taken in reliance therein) at any time by written, dated communication.

Patient Signature:_____

Date:_____

If the patient is unable to give consent because he/she is a minor or has a physical/mental condition, please complete the following required information:

Guardian Signature:_____ Date:_____

I hereby designate_____ to claim my records on my behalf.

ABINGTON MEDICAL SPECIALISTS, P.C.

PATIENT:_____ Date:_____

Thank you for choosing Abington Medical Specialists (AMS) as your provider. We are committed to providing you with the best available care. We ask that all responsible parties read and sign our financial policy. If you have any questions please feel free to ask our staff to discuss any fees or this policy with you. As the responsible party, please understand:

1. AMS will bill your insurance company on your behalf; however, you are ultimately responsible for the bill. Please communicate any problems to us so that we may assist you.
2. You are financially responsible for any balance not covered by your insurance carrier.
3. Co-payments, co-insurances and deductibles are due at the time of your visit. We cannot waive your insurance plan's requirements as we would be in violation of our contract.
4. You are required to pay your portion of any surgery/procedure prior to the procedure date. AMS will provide you with an estimate of your financial responsibility when possible and a date which payment is due. We will work with you to set up a feasible payment plan.
5. Please inform the receptionist of any changes in your address, phone number, insurance coverage.
6. You are responsible for providing a referral from your primary care physician should the insurance require one. If your insurance company denies payment due to non referral, you, the patient, agree to pay AMS in full for any charges incurred during the visit.
7. If you fail to make any payment which you are responsible for, your account may be turned over to a collection agency. You will be responsible for payment of reasonable collection and legal fees.
8. In the event that a check is returned, you are responsible for the amount of the check plus $25.00 bank charges. Payment will then need to be made by cash, money order, or credit card.
9. The completion of disability and/or FMLA forms are not billable/reimbursable by insurance companies, therefore charges are your responsibility. AMS fees related to completion of these forms are $15.00 per form.
10. Confirmation phone calls are made to patients 48-72 hours prior to your appointment as a courtesy reminder of your scheduled appointment. This reminder give you time to cancel and/or reschedule if you cannot keep the appointment. Cancellation must be done 24 hours in advance so that we may accommodate other patients. **There will be a $50.00 charge to New Patients who do not show for the appointment or who do not give at least 24 hours notice. Established patients may be charged $25.00 for not showing for appointments.**

Abington Medical Specialists is authorized to release to my insurance company(s) any necessary information needed to file and expedite payment of my claims. Assignment of any benefits should be payable on my behalf to Abington Medical Specialists.

Print Name _____ D.O. B _____

_____

Signature or legal representative Date

Date: _____

Name: _____ DOB: _____

I give permission for AMS Cardiology to discuss my health care with the following person(s):

1.) Name: _____

Phone: _____

Relationship: _____

2.) Name: _____

Phone: _____

Relationship: _____

Patient's signature: _____