CARDIOVASCULAR ASSOCIATES
OF CHARLOTTESVILLE
Quality Care in a Heartbeat

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PATIENT INFORMATION

Name		Date of Birth
Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		Number of Children
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Oth Pacific Islander ☐ White ☐ Other Race		Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Home Address (e.g., P.O. Box or Street, City, State, Zip)	Mailing Address (if different)	
Home Phone	Work Phone	Cell Phone
Occupation	If retired, previous occupation:	Email Address
Referring Physician	Primary Care Physician	Other Physician(s)/Specialty

We encourage every adult to have an advance directive. This names someone you trust to make decisions if you are unable to say what you want. Do you have an advance directive? ☐ Yes ☐ No (If yes, please bring a copy to our office.)

Would you like free assistance from our hospital affiliate in completing an advance directive? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Name of Contact	Relationship to Patient	
Address (if different than above)		
Home Phone	Work Phone	Cell Phone

PERMISSION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS/FRIENDS

The following person(s) have permission to access my medical records, to receive information about me and my medical history, and to speak to the physician on my behalf.

Name	Relationship	Phone

INSURANCE INFORMATION

Do you have medical insurance? ☐ Yes ☐ No	Primary Insurance:	Secondary Insurance:

Name of Patient:	

ALLERGIES
List all medication or food allergies, as well as your reaction..

CURRENT MEDICATIONS
List ALL current medications including over the counter medications/vitamins/herbals/supplements.

Medication Name	Dosage	# Times Daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

MEDICAL PROBLEMS

☒	Condition	Year	☒	Condition	Year
☐	Angina		☐	Thyroid Disease ☐ Hyper? ☐ Hypo?	
☐	Coronary Artery Disease		☐	Liver Disease	
☐	Heart Attack		☐	Kidney Disease	
☐	Heart Failure (CHF)		☐	Arthritis	
☐	Heart Valve Disease		☐	Migraine Headaches	
	Type:		☐	Seizures	
☐	High Blood Pressure		☐	Stroke	
☐	High Cholesterol		☐	Anemia	
☐	Irregular Heart Rhythm		☐	Bleeding/ Clotting Disorder	
	Type:		☐	Cancer	
☐	Peripheral Vascular Disease			Type:	
☐	Asthma		☐	GERD	
☐	Lung Disease (COPD)		☐	Depression	
☐	Tuberculosis		☐	Emotional/Behavioral Illness	
☐	Colitis			Explain:	
☐	Stomach Ulcer		☐	AIDS/HIV	
☐	Gout		☐	Other	
☐	Diabetes ☐ Type I? ☐ Type II?			Explain:	

Name of Patient:	

PREVIOUS SURGERIES

Surgery	Year
1.	
2.	
3.	
4.	
5.	

FAMILY MEDICAL HISTORY

(**Does anyone in your *immediate family* have the following? Who?**)

☒	Condition	Who?	☒	Condition	Who?
☐	Coronary Artery Disease		☐	Cancer (type)	
☐	Heart Attack		☐	Diabetes	
☐	Sudden Cardiac Death		☐	COPD	
☐	High Blood Pressure		☐	Stroke	
☐	High Cholesterol		☐	Aneurysm: _____	
☐	CHF/Heart Failure		☐	Other	

Father's cause of death	Age	Mother's cause of death	Age

SOCIAL HISTORY

Do you exercise regularly? ☐ Yes ☐ No	Type of Exercise? How Often?

Tobacco Use
(Cigarettes, cigars, pipes, and smokeless tobacco)

☐ Never		
☐ I quit (Year: _____)	Packs/day?	How long?
☐ I still smoke	Packs/day?	No. of years?
☐ Smokeless Tobacco	No. of cans/day?	No. of years?

Alcohol and Drug Use

How often do you drink?	☐ Never	☐ Occasionally	☐ Socially	☐ Daily	☐ Weekly
No. of drinks per week?	☐ Beer	☐ Red Wine	☐ White Wine	☐ Liquor	

Any alcohol-related legal, personal or health problem?	☐ Yes	☐ No
Previous DT's or Seizures?	☐ Yes	☐ No
Treatment for any alcohol-related problem?	☐ Yes	☐ No
Any drug-related legal, personal or health problem?	☐ Yes	☐ No

Name of Patient:	

FINANCIAL POLICIES

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient, To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies or your insurance coverage and your financial responsibilities.

Professional Fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education and training and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time.

Patient Payments: Co-pays, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment. We accept cash, checks, and VISA, MasterCard, and Discover. Returned checks will be subject to a fee of $25.00 charged by this office for each check returned to us by your bank. Please let us know if you are having a particular financial problem and we will try our best to be understanding. Please feel free to discuss mutually acceptable payment arrangements with our billing office.

Insurance Payments: We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims on your behalf, your insurance coverage is a contract between you and your insurer and you are still responsible for payments and services regardless of the amount your insurance pays.

REFERRAL REQUIREMENTS

If my insurance company requires a referral, I understand that I am responsible for obtaining the referral. If the referral is not obtained, I can be held responsible for payment in full for services rendered on the date of service.

NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been offered a copy of Cardiovascular Associates of Charlottesville Notice of Privacy Practices (available in our office or on our website) and understand that the Notice may change at any time. I give consent to Cardiovascular Associates of Charlottesville, PLC to obtain my prior medical records from outside practices and send office notes to other physicians to coordinate care on my behalf.

Patient Name:	Signature of Patient or Legal Representative	Date

DEEMED CONSENT FOR MEDICAL CARE

I voluntarily consent to medical care by Cardiovascular Associates of Charlottesville that may include examinations, tests, photographs, and treatments by physicians and the staff. No promises have been made to me as to the results of treatments or examinations.

CONSENT FOR REVIEW OF PRESCRIPTION HISTORY

I authorize Cardiovascular Associates of Charlottesville to access my prescription history from outside sources to help keep my medical record as complete as possible. This includes many but not necessarily all medications used in the past. I understand my prescription history from other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here.

SIGNATURE

I have read and agree to the above policies.

Patient Name:	Signature of Patient or Legal Representative	Patient Name:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other