

FOLLOW-UP VISIT PATIENT INTAKE FORM
(Page 1 of 2)

Name: _____ Date of Visit: _____
Date of Birth: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

Current Medications (List all including non-prescription drugs, vitamins, etc):

Medical/Surgical History:

Since the last visit here has the patient: Yes No
 Been diagnosed with a new medical problem or had a change in an existing medical problem ☐ ☐
 Been admitted to the hospital or had an unexpected visit to the doctor or emergency room..... ☐ ☐
 Had surgery or any other procedure ☐ ☐
 Started seeing a new primary doctor, specialist, therapist ☐ ☐

If you answered "Yes" above, please explain: _____

Family History:

Since the last visit here, has anyone in the patient's family developed or been born with Yes.....No
 a new significant heart problem ☐ ☐

If you answered "Yes" above, please explain: _____

ALLERGY HISTORY:

☐ None ☐ NKDA (No Known Drug Allergies)

☐ Acetaminophen (Tylenol) ☐ Aspirin ☐ Iodinated Contrast Media ☐ Penicillin ☐ Sulfa Drugs
☐ Other: _____

SOCIAL HISTORY:

Please describe the patient's immediate family members? ☐ Mother ☐ Father ☐ Brother(s) _____ ☐ Sister(s) _____

Other (list): _____

Please describe your (the patient's) *current* School Status? ☐ Regular school ☐ Special education ☐ Full-time ☐ Part-time

Please describe your (the patient's) *current* Tobacco Use/Exposure?

Tobacco/Smoke 2nd hand Exposure Details: ☐ None ☐ Minimal ☐ Frequent ☐ Daily

☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoked ☐ Unknown

Have you (the patient) ever used any illicit drugs? ☐ Yes ☐ No

If yes, please indicate what type of drug and how often: _____

Do you (the patient) drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: _____

Do you (the patient) drink caffeinated beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: _____

Please describe your (the patient's) current exercise routine: ☐ Inactive ☐ Light ☐ Moderate ☐ Heavy ☐ Vigorous

FOLLOW UP PATIENT INTAKE FORM (Page 2 of 2)

REVIEW OF SYSTEMS:

Has the patient recently experienced any of the following symptoms? *Please mark either Yes or No for each of the items below.* Your doctor will discuss any positive responses with you.

General: Yes No <ul style="list-style-type: none"> • Easy Fatigue..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Frequent Infections..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Paleness..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Poor Weight Gain..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Recent Weight Loss..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Recent Weight Gain..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	HEENT: Yes No <ul style="list-style-type: none"> • Blurry Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Cracked/Sore/Red Lips..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Ear Pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Glasses/Contact Lenses..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Hearing Loss..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Loss or Change of Vision..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Nasal Congestion..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Nosebleed..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Pink/Red Eyes..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Seasonal/Chronic Runny Nose..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Sore Throat..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Watery Eyes..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	Neck: Yes No <ul style="list-style-type: none"> • Neck Pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Neck Stiffness..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Neck Swelling..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Skin: Yes No <ul style="list-style-type: none"> • Abnormal Color: Blue or Very Pale..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Eczema..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Hemangiomas/Birthmarks..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Prominent Veins..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Rash..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	Respiratory: Yes No <ul style="list-style-type: none"> • Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Chest Pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Difficulty Breathing..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Frequent Coughing..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Lung Collapse..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Noisy Breathing..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Pneumonia..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Shortness of Breath..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Wheezing..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	Cardiovascular: Yes No <ul style="list-style-type: none"> • Blueness..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Chest Pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Dizziness..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Easy Fatigue..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Heart Murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No • High Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No • High Cholesterol..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Irregular Heart Beat..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Low Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Palpitations or Rapid Heart Beat..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Passing Out..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Poor Exercise Tolerance..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal: Yes No <ul style="list-style-type: none"> • Coughing/ Choking when Eating..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Difficulty Feeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Frequent Diarrhea..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Frequent Vomiting..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Heartburn/Stomach Aches..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Poor Eater..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	Genitourinary: Yes No <ul style="list-style-type: none"> • Blood in Urine..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Decreased Urine..... <input type="checkbox"/> Yes <input type="checkbox"/> No • History of Urinary Tract Infections..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Painful Urination..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	Psychiatric: Yes No <ul style="list-style-type: none"> • Depression..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Mood Swings..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Nervousness..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Temper Outburst..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Musculoskeletal: Yes No <ul style="list-style-type: none"> • Chest Cavity Abnormality..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Joint or Muscle Pain..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Joint or Muscle Swelling..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Loose/Flexible Joints..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Redness/ Inflammation of Joints..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Scoliosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	Endocrine/Glands: Yes No <ul style="list-style-type: none"> • Excessive Sweating..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Excessive Thirst/Hunger..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Heat or Cold Intolerance..... <input type="checkbox"/> Yes <input type="checkbox"/> No 	Neurological: Yes No <ul style="list-style-type: none"> • Abnormal Movements..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Diagnosis of ADHD/ADD..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Difficulty Speaking..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Headaches..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Numbness..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Seizures..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Weakness..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hematology: Yes No <ul style="list-style-type: none"> • Anemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Easy Bruising/Bleeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No • Swollen/Enlarged Lymph Nodes..... <input type="checkbox"/> Yes <input type="checkbox"/> No 		

Form Filled Out By:

☐ Patient, ☐ Mother, ☐ Father, ☐ Relative: _____, ☐ Staff: _____, ☐ Translator: _____

Physician Review: _____ Date: _____

☐ AMV ☐ SGL ☐ DML ☐ AMSI

PEDIATRIC CARDIOLOGY OF LONG ISLAND, P.C.

100 PORT WASHINGTON BOULEVARD, ROSLYN, NY 11576 516-365-3340 - FAX: 516-908-4214
232 BARNUM AVENUE, PORT JEFFERSON, NY 11777 631-331-5014
661 DEER PARK AVENUE, BABYLON, NY 11702 631-669-9624

ACCOUNT#: _____

PATIENT'S NAME: _____
LAST FIRST M.I.

DATE OF BIRTH: _____ SEX: _____

PATIENT'S STREET ADDRESS: _____

CITY, STATE: _____ ZIP CODE: _____

CELL PHONE (1): _____ CONTACT NAME: _____

ALTERNATE # (2): _____ CONTACT NAME: _____

PARENT/LEGAL GUARDIAN INFORMATION:

Parent/Guardian # 1:

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Address: _____

Parent/Guardian # 2:

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Address: _____

INSURANCE INFORMATION:

PRIMARY:

INSURANCE COMPANY NAME: _____

ID NUMBER: _____ GROUP NUMBER: _____

NAME OF POLICY HOLDER: _____ DOB: _____

POLICY HOLDER ADDRESS: _____

RELATIONSHIP TO POLICY HOLDER: _____

SECONDARY:

INSURANCE COMPANY NAME: _____

ID NUMBER: _____ GROUP NUMBER: _____

NAME OF POLICY HOLDER: _____ DOB: _____

POLICY HOLDER ADDRESS: _____

RELATIONSHIP TO POLICY HOLDER: _____

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

PLEASE LIST ANY DOCTORS THAT WILL REQUIRE THE RESULTS FROM THIS CARDIOLOGY VISIT.
CONSULTATION LETTERS WILL BE FAXED TO THE DOCTORS WRITTEN BELOW.

Requests for medical records to be sent to anyone not listed below, will require a medical record release form to be completed on our website.

PRIMARY CARE PHYSICIAN:

NAME: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP: _____

PHONE: _____

ADDITIONAL DOCTORS:

NAME/TYPE OF PHYSICIAN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

NAME/TYPE OF PHYSICIAN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

NAME/TYPE OF PHYSICIAN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Co-payment, Co-Insurance and Deductible

We appreciate your confidence in choosing Pediatric Cardiology of Long Island. Please take a moment to review our office financial policy below.

CO-PAYMENTS:

If you are enrolled in a managed care plan which we are contracted, you are required to pay the specialist co-payment each time you are seen. This must be paid prior to being seen. If you are not prepared at the time of service, there will be a \$25.00 surcharge imposed.

CO-INSURANCE:

In addition to co-payments and deductibles, some plans have a co-insurance. This is a percentage of the reimbursement amount that you and your insurance company have agreed upon. It is YOUR responsibility to know your co-insurance prior to being seen.

A credit card is kept on file for these balances. The billing department will contact you prior to charging your card. If we do not receive payment after 90 days, the card will automatically be charged.

DEDUCTIBLE:

In addition to co-payments and co-insurances, some plans have an annual deductible. This can either be an individual deductible or a family deductible. It is YOUR responsibility to know the amount of your deductible and whether it has been met, prior to your visit.

A credit card is kept on file for these balances. The billing department will contact you prior to charging your card. If we do not receive payment after 90 days, the card will automatically be charged.

It is the responsibility of the parent, policy holder or patient to be familiar with their insurance policy. It is impossible to get any guarantee of payment until a claim is submitted. Therefore, the patient/parent/guardian is liable for any charges that are not covered under their contract.

DIVORCED/SEPARATED PARENTS OF MINOR CHILDREN:

The parent who consents to the treatment of a minor child is responsible for payment of copayment, co-insurance, deductible and all services rendered. Pediatric Cardiology of Long Island will not be involved with separation or divorce disputes.

It is our office policy to send three bills. After 90 days your account will incur finance charges every month, for which you are responsible. Your final statement will advise you that the balance will be turned over to a collection agency. You will be responsible for the insurance balance, finance charges and any costs which may result from collection proceedings. To avoid this, please pay your bill promptly. If you do not understand the reason for the balance, please do not hesitate to contact our office. We are always willing to set up a payment plan.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

FINANCIAL WAIVER

In consideration of services rendered by your physician at Pediatric Cardiology of Long Island to the undersigned patient, the undersigned promise(s) to pay Pediatric Cardiology of Long Island any co-payment, co-insurance, deductible or other charges required to be paid by my health insurance coverage.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature:

HIPAA PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely. As is required by the new law, we have highlighted the points of interest for your review.

Background:

In 1996, Congress recognized the need for national patient privacy standard and as part of the Health Insurance Portability and Accountability Act (HIPAA), ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals, and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for bank accounts, credit cards, and even video rentals.

- By the law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows, also, for a prescription to be called into your pharmacy and for scheduling of surgery in a hospital.
- Additionally, no consent is needed in the course of carrying out health care operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.
- However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent.
- Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer or for use in marketing a product to you.
- Medical information about you may be released for research and public health uses as long as you are not individually identified.
- You have the right to request the release of your medical information.
- You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.
- Portions of this notice may be modified and/or amended per government regulations.
- The law requires that you acknowledge receipt of this notice.

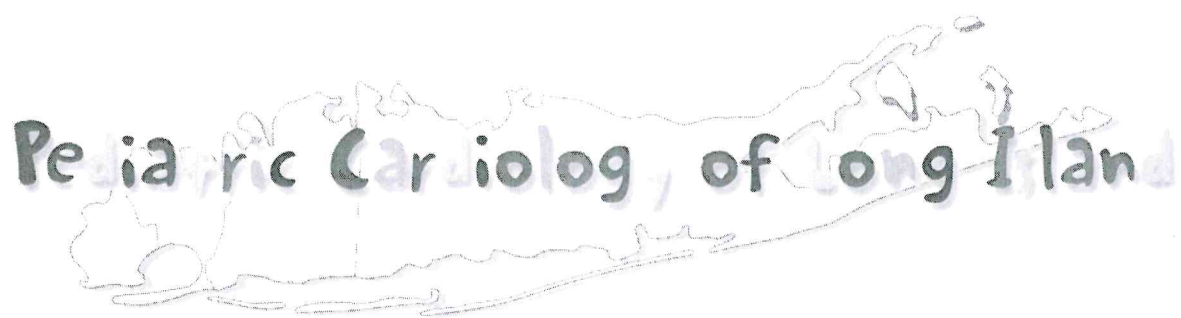
Thank you.

Pediatric Cardiology of Long Island

I have reviewed a copy of Pediatric Cardiology of Long Island's Notice of Privacy Practices.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature:



Staff Signature: _____ Date: _____

Staff Signature: _____ Date: _____