Pediatric Cardiology of Long Island

INITIAL VISIT PATIENT INTAKE FORM
(Page 1 of 4)

Date of Visit: _____

Name: _____ **Date of Birth:** _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ More Than One Race
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Refused to Report/Unreported

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report/Unreported

Language: ☐ English ☐ Spanish Other: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

Timing/Onset: When did symptoms first occur? _____

Duration: Frequency of symptoms? _____

Characterized as/Severity: In your own/your child's words, describe the symptoms/pain. _____

_____

Associated Signs and Symptoms: Are there any other symptoms associated with your problem? _____

_____

Modifying Factors: What makes the condition better and/or worse? _____

_____

BIRTH HISTORY: *Please describe the patients:*

Gestational age: ☐ Pre-term (how many weeks) _____ ☐ Full Term ☐ Post-term

Pregnancy complications: ☐ None ☐ Other: _____

Delivery mode: ☐ Vaginal delivery ☐ C-Section

Delivery complications: ☐ None ☐ Other: _____

Birth weight: _____

Hospital stay: ☐ Routine newborn care (Home on: ☐ Day 2 ☐ Day 4 ☐ Other ____) ☐ Neonatal ICU (How long ____)
☐ Other: _____

PAST MEDICAL HISTORY: *Has the patient ever been diagnosed with any of the following (currently or in the past):*

☐ ADD	☐ Anemia	☐ Cancer	☐ Down Syndrome	☐ High Cholesterol
☐ ADHD	☐ Anxiety	☐ Diabetes	☐ Genetic Problem	☐ Seizures
☐ Allergies	☐ Asthma	☐ Depression	☐ High Blood Pressure	☐ Thyroid Problem

☐ Other: _____

_____

_____

_____

ALLERGY HISTORY:

☐ **None** ☐ **NKDA (No Known Drug Allergies)**

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

☐ Other: _____

_____

PAST SURGICAL HISTORY:

List significant surgeries or injuries (Write "None" if you have no past surgeries or injuries):

Surgeries/Injuries — *Date(s) or Age/Surgeon*

_____

_____

_____

_____

MEDICATION HISTORY: *List any prescription or over the counter medications, vitamins, minerals, and herbals that you (the patient) are currently taking:*

☐ **Not currently taking any medications**

Name of Medication	Dosage	Name of Medication	Dosage

FAMILY HISTORY:

Has a member of the patient's family (parents, siblings, grandparents, aunts, uncles, cousins) been diagnosed with any of the following conditions (include deceased family members)? *Place an "X" under the family member with the condition, and indicate if the family member passed away due to that condition.*

	Mother	Father	Sibling(s)	Grandparent(s)	Other
☐ Aneurysms					
☐ Arrhythmia					
☐ Cardiomyopathy					
☐ Congenital Heart Defect					
☐ Deafness at birth					
☐ Diabetes					
☐ Enlarged Heart					
☐ Heart Attack < age 50					
☐ Heart Disease as adult					
☐ Heart Surgery					
☐ High Blood Pressure					
☐ High Cholesterol					
☐ Irregular Heart Beats					
☐ Lupus					
☐ Marfan Syndrome					
☐ Mitral Valve Prolapse					
☐ Pacemaker/Defibrillator					
☐ Prolonged QT Syndrome					
☐ Stillbirths					
☐ Stroke					
☐ SIDS					
☐ Sudden/Accidental Death					
☐ Syncope/Passing out					
☐ Tachycardia					
☐ Valve Leak/Narrowing					

☐ Other: _____

_____

_____

SOCIAL HISTORY:

Please list 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?
Current every day smoker Current some day smoker Former Smoker Never Smoked Unknown
Tobacco/Smoke 2nd hand Exposure Details: None Minimal Frequent Daily

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

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
• Easy Fatigue		
• Frequent Infections		
• Paleness		
• Poor Weight Gain		
• Recent Weight Gain		
• Recent Weight Loss		

Skin:	Yes	No
•Abnormal Color: Blue or Very Pale		
•Eczema		
•Hemangiomas/Birthmarks		
•Prominent Veins		
•Rash		

HEENT:	Yes	No
•Blurry Vision		
•Cracked/Sore/Red Lips		
•Ear Pain		
•Glasses/Contact Lenses		
•Hearing Loss		
•Loss or Change of Vision		
•Nasal Congestion		
•Nosebleed		
•Pink/Red Eyes		
•Seasonal/Chronic Runny Nose		
•Sore Throat		
•Watery Eyes		

Neck:	Yes	No
•Neck Pain		
•Neck Stiffness		
•Neck Swelling		

Respiratory:	Yes	No
•Asthma		
•Chest Pain		
•Difficulty Breathing		
•Frequent Coughing		
•Lung Collapse		
•Noisy Breathing		
•Pneumonia		
•Shortness of Breath		
•Wheezing		

(Review of Systems continued)

Cardiovascular:	Yes	No
• Blueness		
• Chest Pain		
• Dizziness		
• Easy Fatigue		
• Heart Murmur		
• High Blood Pressure		
• High Cholesterol		
• Irregular Heart Beat		
• Low Blood Pressure		
• Palpitations or Rapid Heart Beat		
• Passing Out		
• Poor Exercise Tolerance		

Gastrointestinal:	Yes	No
• Coughing/ Choking when Eating		
• Difficulty Feeding		
• Frequent Diarrhea		
• Frequent Vomiting		
• Heartburn/Stomach Aches		
• Poor Eater		

Genitourinary:	Yes	No
• Blood in Urine		
• Decreased Urine		
• History of Urinary Tract Infections		
• Painful Urination		

Musculoskeletal:	Yes	No
• Chest Cavity Abnormality		
• Joint or Muscle Pain		
• Joint or Muscle Swelling		
• Loose/Flexible Joints		
• Redness/ Inflammation of Joints		
• Scoliosis		

Neurological:	Yes	No
• Abnormal Movements		
• Diagnosis of ADHD/ADD		
• Difficulty Speaking		
• Headaches		
• Numbness		
• Seizures		
• Weakness		

Psychiatric:	Yes	No
• Depression		
• Mood Swings		
• Nervousness		
• Temper Outburst		

Endocrine/Glands:	Yes	No
• Excessive Sweating		
• Excessive Thirst/Hunger		
• Heat or Cold Intolerance		

Hematology:	Yes	No
• Anemia		
• Easy Bruising/Bleeding		
• Swollen/Enlarged Lymph Nodes		

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 DOCTQRS:

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 you medical treatment with you 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 of 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.

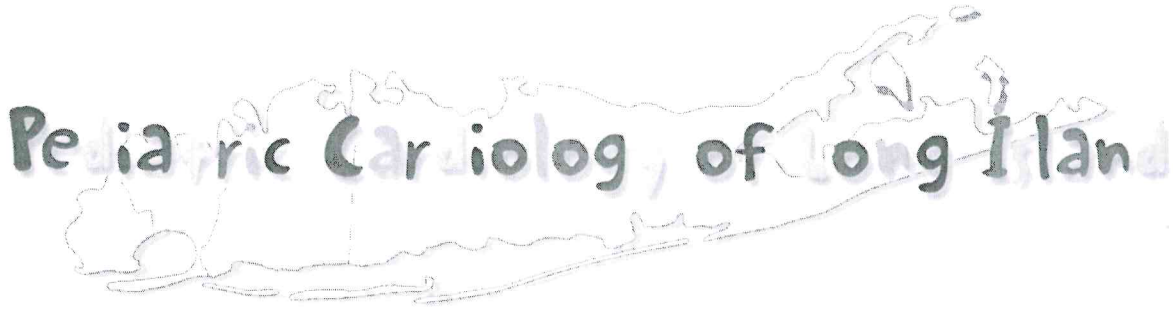
Pediatric Cardiology of Long Island

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: _____