Heartland CARDIOLOGY LLC

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NEW PATIENT INFORMATION

Date: _____

Dear: _____

You are scheduled for an appointment with:

Dr. _____

Location: **9300 E. 29th St. N, Suite 310**
Phone: 316-651-8900

Date: _____ Time: _____

1. Please complete the enclosed forms and bring them with you to your appointment.
2. Bring a copy of your insurance card AND photo ID to your appointment.
3. Bring all medications you are currently taking, in the bottles.
4. If you have had a chest x-ray within the past month, please let our staff know. If you have not had a chest x-ray within the past month, our physician may order one on the day of your visit.
5. **It is very important that we have your past pertinent medical records.** Please verify that these records are being mailed or faxed to our office from your referring physician's office prior to your appointment. This allows our physician to review your records prior to your appointment.
6. If you are a member of a managed health plan such as Coventry HMO, HMO Kansas, Preferred Plus of Kansas, AETNA Managed Choice, CIGNA, Premier Blue or Blue Select, you will need to obtain a written referral from your primary care physician. You may verify in advance that your referring physician's office is taking care of any necessary referrals. If you have any questions, please contact our office for assistance.
7. **If you are a member of any insurance plan that requires a written referral and you do not obtain authorization from your primary care physician prior to your visit, you will be responsible for all charges at this appointment.**

Phone: 316-686-5300 or 1-888-432-7833 **Fax:** 316-651-2660

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Date: _____ Doctor: _____

Last Name:_____ First Name: _____ M. I. _____

Date of Birth: _____ Age: _____ Sex: M or F SS#: _____

Address: _____ Phone #: _____

City, State, Zip: _____ Alt. Phone #: _____

Occupation: _____ Do you reside in a nursing home? Yes No

If Yes, Name of Facility: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Care Physician: _____

Briefly describe your present symptoms: _____

_____

_____

Cardiac Risk Factors:

Smoker?	Yes	No	How much or when did you quit? _____
High Blood Pressure?	Yes	No	How long has it been present? _____
Diabetes Mellitus?	Yes	No	How long has it been present? _____
High Cholesterol?	Yes	No	How high has it been? _____

Family with Heart Disease? _____

Allergies? _____

Medications (Name, Dose, How Often) Please list heart-related medications first:

1._____ 6._____
2. _____ 7._____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10._____

Surgeries or Procedures. Please list heart-related surgeries first:

Operation Date Hospital Doctor

_____

_____

_____

Other Medical Conditions:

_____

_____

Please continue on reverse side

Health-Related Questions (Please Circle and fill in responses)

Yes No Has your weight changed significantly? How has it changed?

Yes No Do you ever get dizzy or pass out?

Yes No Have you briefly lost your vision, especially in just one eye?

Yes No Are you ever short of breath?

Yes No Do you have difficulty breathing when lying down flat?

Yes No Do you wake up in the middle of the night in order to breathe?

Yes No Do you ever have chest discomfort? If yes, fill in below:

Where is the chest discomfort?

What does the chest discomfort feel like?

Where does the chest discomfort go?

What makes the chest discomfort begin?

What makes the chest discomfort stop?

Yes No Do you ever have heart palpitations, skipping or fluttering? If yes, fill in below:

When do these palpitations occur?

What makes these palpitations begin?

What makes these palpitations stop?

Do you ever feel any other symptoms during the palpitations?

Yes No Do your legs ever swell?

Yes No Do you consume alcoholic beverages? How much? _____

Yes No Do you consume caffeinated beverages? How much? _____

Yes No Are you employed? If yes, list your job duties:

_____

_____

Please continue on reverse side