NEW PATIENT INFORMATION

Heartland CARDIOLOGY LLC

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Date: _____

Dear: _____

You are scheduled for an appointment with:

Dr. _____

Location: **551 N. Hillside, Suite 410, Wichita, KS 67214**
Phone: Heartland Cardiology: 316-686-5300

Date: _____ **Time:** _____

1. Please complete the enclosed forms and bring them with you to your appointment.

2. Please bring your insurance card(s) AND photo ID to your appointment.

3. **Bring all medications you are currently taking, in the bottles.**

4. **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.

5. If you are a member of a managed health plan such as Coventry HMO/POS, AETNA, CIGNA, TriCare, or UHC Compass, 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.

6. **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.**

Last Name:_____

First Name:_____ Middle Initial:_____

Address:_____

City:_____ St:____ Zip:_____

Primary Phone:(____)____-_____ Mobile :(____)____-_____

Work Phone:(____)_____-_____

Place of Employment:_____

Primary Care Doctor:_____

Referring Doctor:_____

Are you currently seen by another Cardiologist? Yes/ No

If yes, please provide name:_____

DOB:____/_____/_____ Social Security Number:_____-_____-_____

Marital Status: Married Single Divorced Widowed

Primary Insurance:_____SecondaryInsurance:_____

Policyholder's Name:_____ Policyholder's Name:_____

Policyholder's DOB: ____/_____/_____ Policyholder's DOB: _____/_____/_____

Emergency Contact:_____ Phone: (_____)_____-_____

Relationship:_____

Pharmacy:_____Address:_____

Patient Name: _____

Reason for today's visit:_____

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

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

Medical History: Please circle all that apply

High Blood Pressure / Heart Attack / Stroke / High Cholesterol / Diabetes / Coronary Artery Disease

Palpitations / Dizziness / Shortness of Breath / Irregular Heartbeat / Leg Swelling / Leg Pain

Other Medical History:_____

Allergies/Intolerances:_____

Surgical History

Family History (Please check all boxes that apply)

Member	Living?	Age	Heart Attack	Heart Disease	Unknown	High Blood Pressure	Diabetes	Stroke	Mental Illness	Cancer
Father										
Mother										
Siblings										
Other										

Social History

Alcohol Consumption: YES / NO How much/How Often:_____
Recreational Drug Use: YES / NO Drug name/How Often:_____
Caffeine: YES / NO Type/Amount/How Often:_____
Marital Status: Married Single Divorced Widowed
Occupation:_____
Exercise: YES / NO Type/How Often:_____
Smoker: YES / NO/ Former Type/How long:_____ Interested in Quitting? YES / NO
* FORMER Smoker: How much did you smoke?:_____How long ago did you quit?:_____

Other Medical Conditions Not Listed Above:

_____

_____

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Patient Name: _____

Do you have any of the following symptoms?

YES NO Chest pain

YES NO Shortness of Breath
Mild Activity Moderate Activity Severe Activity

YES NO Dizziness

YES NO Palpitations

YES NO Swelling in legs/feet

YES NO Leg cramps
Mild Activity Moderate Activity Severe Activity

Do you lay flat to sleep? YES / NO

How many pillows do you use at night? _____

Do you wake up at night gasping for air? YES/NO

Energy Level GOOD/ FAIR/ POOR

Do you have any cardiac concerns? YES / NO If yes, please explain

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