NEW PATIENT INFORMATION

Ravi K. Bajaj, M.D. | Husam Bakdash, M.D. | Charles Beck, M.D.
Venkata Boppana, M.D. | Zaher Fanari, M.D. | Assem Z. Farhat, M.D.
Hussam Farhoud, M.D. | Shilpa Kshatriya, M.D. | Abid K. Mallick, M.D.
Wassim Shaheen, M.D. | Ghiyath Tabbal, M.D. | Saad Z. Farhat, M.D.
Madan Acharya, M.D. | Peeyush Grover, M.D.

Date: ______________________________

Dear: ____

You are scheduled for an appointment with:

Dr. _________________________________

Location: **1719 E. Cambridge, Suite 101, Derby, KS 67037**
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

Race/Ethnic Group: ___ American Indian/Alaskan ___ Asian/Pacific Islander

___ Black/African American ___Caucasian/White ___ Hispanic ___ Other

Primary Insurance:______________________________SecondaryInsurance:________________________

Policyholder's Name:_________________ Policyholder's Name:______________________

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

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Family History (Please check all boxes that apply)

Family Member	Living?	Age	Heart Attack	Hypertension	Diabetes	CVA	Mental Illness	Cancer	Ventricular Dysfunction
Father									
Mother									
Sibling									
Sibling									

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:

____

____

Patient Name: ____ Date of Birth: _________

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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