Kansas City Cardiology

Patient Information

Updated: _____/_____/_____ Primary Care Physician: _____ Referring Physician: _____

Last Name: _____ **First:** _____ **MI:** _____

Date of Birth:_____/_____/_____ **Age:** _____ **Gender:** _____

Address/City/State/Zip _____

Home Phone: _____ **Cell Phone:** _____ **Social Security:** _____

Responsible Party. (if other than patient): _____ **Relationship to Patient:** _____

Race: *please check one* o White o Asian o African American o American Indian or Alaska Native o Native Hawaiian or other Pacific Islander o other o Decline to Report

Ethnicity: o Hispanic or Latino o Not Hispanic or Latino o Refused to report **Primary language:** o English o Spanish **Interpreter needed?** o Yes o No

Email Address for Web Portal: _____ Pharmacy of Choice/Location: _____

Emergency Contact: _____ Phone Number: _____

How would you like to receive appointment reminders:(*please check one)* o Home number o Cell number o Text message

HEALTH INSURANCE***

Primary Insurance: _____ **Secondary Insurance:** _____

ID Number: _____ Group Number: _____ **ID Number:** _____ Group Number: _____

Policy Holder: _____ Policy Holder: _____

***** If you do not present a copy of your insurance card, you will be responsible for all office and surgery charges incurred until we receive a copy of the from and back of the card(s).**

Insurance Policy Holder *(other than self)*

Name: _____ **Date of Birth:**_____/_____/_____ **Social Security:** _____

Address/City/State/Zip _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Relationship to Patient: _____ **Employer:** _____

Insurance Authorization & Assignment/Consent to Treatment: I hereby authorize St. Joseph/St. Mary's Medical Group to furnish information to insurance carriers concerning my dependents illness or myself and treatments and I hereby assign to the physician (s) all payments for medical services to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. (Must be signed regardless of insurance coverage)

Signature _____ **Date:**_____/_____/_____

Lifetime Consent - Medicare Patients Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to St. Joseph/St. Mary's Medical Group for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the healthcare financing administration and it agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ **Date:**_____/_____/_____

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Patient History

Name:_____ Date of Birth:_____/_____/_____ Date:_____/_____/_____

In order to ensure that we have an accurate and current medical history for you, please complete this system review at each visit. Check all problems that apply to you. Please use the space at the bottom of the form to let our care staff know any changes in your health status since your last visit with us. Thank you.

System Review *(Please check all that apply)*

ENT:
___Difficulty hearing
___Earache
___Noises in ears
___Nasal stuffiness
___Nosebleeds
___Persistent hoarseness
___Sore or bleeding gums
___Sore tongue
___Frequent head colds

Eyes:
___Wear glasses
___Impaired vision
___Irritation of eyes
___Watering of eyes

Respiratory:
___Shortness of breath
___Wheezing
___Raise phlegm
___Cough up blood
___Daily cough

Cardiac:
___Chest pain
___Irregular heartbeat
___High blood pressure
___Leg swelling

Gastrointestinal:
___Poor appetite
___Trouble swallowing
___Nausea or vomiting
___Indigestion
___Heartburn
___Abdominal pain or distress
___Gas or bloating
___Constipation
___Blood in stools
___Diarrhea or dysentery

Genitourinary:
___Getting up more than once a night to urinate
___Trouble starting stream
___Trouble emptying bladder
___Blood in urine

Gynecological:
(Females Only)
___Menopause
___Hormonal replacement
___Birth control pills

Neurological:
___Bad headaches
___Blackout spells
___Convulsions
___Paralysis
___Numbness of hands
___Numbness of feet

Musculoskeletal:
___Frequent back pain
___Rheumatism or arthritis
___Localized weakness
___General weakness

Psychiatric:
___Nervous or upset
___Feeling depressed

Endocrine:
___Hormonal problems
___Heart palpitations
___Bulging eyes

Integumentary:
___Sebaceous cysts
___Skin cancer
___Lumps in breasts
___Breast cancer

Immune system:
___Multiple infections
___Immune deficiency
___Seasonal allergies

General:
___Fatigue
___Fever or sweats
___Weight loss? Amount _____
___Weight gain? Amount _____
___Sleeping problems?
___Excessive daytime sleepiness
___Snoring
___Witnessed apnea *(someone has reported you stop breathing during sleep)*
___A.M. Headaches
___Difficulty Sleeping

Lung Cancer Screening:
___age 55-77 years old
___current smoker or quit in last 15 years
___Number of years you smoked
___Average number of packs smoked per day

Changes in Health Status:_____