



**Cardiovascular Associates, S.C.** [www.cvamd.com](http://www.cvamd.com)

800 Biesterfield Road  
Wimmer Bldg Ground Floor  
Elk Grove Village, IL 60007

1555 Barrington Road  
Doc. Bldg. III Suite 4250  
Hoffman Estates, IL 60195

27750 West Highway 22  
Suite 230  
Barrington, IL 60010

1750 Randall Road  
Randall Meadows # 260  
Elgin, IL 60123

Patient Name \_\_\_\_\_ Gender M \_\_\_\_\_ F \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone # ( ) \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_

Employer \_\_\_\_\_

Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Address \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Address \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary**

Insurance name \_\_\_\_\_

Insurance address \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Subscriber name \_\_\_\_\_ Relationship \_\_\_\_\_

Gender M \_\_\_\_\_ F \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary**

Insurance name \_\_\_\_\_

Insurance address \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Subscriber name \_\_\_\_\_ Relationship \_\_\_\_\_

Gender M \_\_\_\_\_ F \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**In Case of Emergency, notify**

\_\_\_\_\_

**Relationship** \_\_\_\_\_ **Phone # ( )** \_\_\_\_\_

I hereby authorize my insurance benefits to be paid directly to the above-signed physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers. Although my insurance company may cover my services, I am aware that I am personally responsible for all charges. A Photostat copy of this authorization will be as valid as the original.

**Signature of patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Cardiovascular Associates  
Medical History**

**Name:** \_\_\_\_\_ **Sex:** M \_\_\_ F \_\_\_ **Date:** \_\_\_\_\_

**Referred by:** \_\_\_\_\_

**Current Medical Problem:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Medications:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:**

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Ulcer
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer

Other \_\_\_\_\_

**Past Surgical History (or Hospitalizations)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Who do you live with? \_\_\_\_\_ what type of work? \_\_\_\_\_

Recreational Activities? \_\_\_\_\_

Smoke? N \_\_\_\_\_ Y (how much?) \_\_\_\_\_ (how long?) \_\_\_\_\_

Alcohol? N \_\_\_\_\_ Y (how much?) \_\_\_\_\_ Caffeine? N \_\_\_\_\_ Y (how much) \_\_\_\_\_

**Family History:**

High Blood Pressure? Father \_\_\_\_\_ Mother \_\_\_\_\_ Brother/Sister \_\_\_\_\_

Heart attack? Father \_\_\_\_\_ Mother \_\_\_\_\_ Brother/Sister \_\_\_\_\_

Diabetes? Father \_\_\_\_\_ Mother \_\_\_\_\_ Brother/Sister \_\_\_\_\_

Stroke? Father \_\_\_\_\_ Mother \_\_\_\_\_ Brother/Sister \_\_\_\_\_

Heart Disease? Father \_\_\_\_\_ Mother \_\_\_\_\_ Brother/Sister \_\_\_\_\_

Cancer? Father \_\_\_\_\_ Mother \_\_\_\_\_ Brother/Sister \_\_\_\_\_

**Other Problems:**

Chest Discomfort     Irregular Heart Beats     Shortness of Breath     Nausea

Indigestion     Dizziness     Leg Swelling     Leg Pain

Other: \_\_\_\_\_

**If you have a specific request for method of releasing your medical information, please list:**

\_\_\_\_\_

Form Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

(For physician Use Only) Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## PATIENT AGREEMENTS AND AUTHORIZATIONS

**CONSENT FOR TREATMENT.** I hereby consent to the treatment provided by Cardiovascular Associates S.C. and its employees or designees I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. ( )

**AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.**

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. ( )

**ASSIGNMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTEE/ COLLECTION FEE.**

I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorneys fees. ( )

**PRIVACY POLICY.** I acknowledge having received the Practice's, "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent. ( )

**ROUTINE COMMUNICATION OF MEDICAL INFORMATION.** I acknowledge that the present communication method(s) that my physician and his/her staff follow to confirm appointments, inform me of my test results and changes to my treatment plan are acceptable to me. I acknowledge that I can request a reasonable alternative method of communication by listing it below. ( )

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient or Authorized Person Signature                      Relationship                      Date

\_\_\_\_\_  
Witness Signature                      Date

Patient unable to sign. Verbal consent given. Reason: \_\_\_\_\_

**CARDIOVASCULAR ASSOCIATES S.C.**

800 Biesterfield Rd.  
Elk Grove Village, IL 60007  
847-981-3680 (F) 847-956-5122

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize records/information about my medical condition to be released to Cardiovascular Associates S.C. **FROM:**

I hereby authorize Cardiovascular Associates S.C. to **RELEASE INFORMATION TO:**

Name: (please print) \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

**Re: Patient**

Name: (please print) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Release the following:

- Only ascular ScreeningV
- Entire medical Record
- Emergency Room Report (s)
- Other \_\_\_\_\_
- History and Physical (s)
- Discharge Summary (s)
- Consult Report (s)
- Operative Report (s)

Concerning the care of the above patient from

\_\_\_\_\_  
(DATES OF TREATMENT)

for the purpose of:

- Physician or Health Care Facility
- Consult (second opinion)
- Seeking a New Physician
- Dissatisfied with Service
- Relocation
- Requested from Government Agency
- Personal Use
- Legal purpose
- Other \_\_\_\_\_

In accordance with Federal Regulations, I understand that these records may include any and all information related to any MEDICAL, ALCOHOL/DRUG ABUSE, PSYCHIATRIC TREATMENT, and HIV OR AIDS RELATED CONDITIONS. I understand that I have the right to revoke this consent at any given time by giving written notice to Cardiovascular Associates S.C., except to the extent that action has been taken in reliance on this authorization. If not revoked, this authorization expires 90 days from date signed. I hereby release Cardiovascular Associates S.C. from any legal responsibilities or liability for disclosure of the above information to the extent indicated and authorized herein.

Redisclosure: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient named above that their health information disclosed under this Authorization might be re-disclosed by the recipient to others. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug/alcohol abuse.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

I authorize \_\_\_\_\_ to pick up my medical record information in the event I am unable to.