CTSA CARDIAC & THORACIC SURGERY ASSOCIATES

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800.204.9896
www.ctsurgery.com

Locations
Denver
St. Anthony Hospital
St. Anthony North Hospital

Colorado Springs
Penrose Hospital

Pueblo
Parkview Medical Center
St. Mary Corwin Medical Center

Longmont
Longmont United Hospital

Durango
Mercy Regional Medical Center

Dear Patient,

We would like to welcome you to our practice and look forward to meeting you at your upcoming appointment. In order to make the experience as meaningful and helpful as possible, we ask your assistance with a few matters.

Enclosed is the new patient information form. **Please have it filled out completely, along with the medication sheet provided, prior to your office appointment.** You will need to bring this with you to make sure we have a current list of your medications. Your medication list needs to include the name of the medicine and/or herbal treatment, dosage and number of times per day you take it.

Please arrive 45 minutes prior to your appointment to complete necessary new patient processing; failure to arrive early may result in your appointment being rescheduled. If you need help walking or assistance with a wheelchair, please bring someone with you that can assist you. **If you need to reschedule for an unseen circumstance, we request a 24 hour notice.**

Although we often receive reports of the imaging studies you have had performed (CT scans, cardiac catheterization, CTA's, echocardiograms, etc) we need to review those images personally in order to appropriately evaluate your condition. **We request that you bring all diagnostic images (often now available on compact disc) with you to your appointment. Please do not have them mailed.** Without these images we may not be able to fully evaluate your condition and another office visit may be required. We do have access to images made at Penrose Hospital, Penrad Imaging and Memorial Hospital. However, we do not have access to other facilities. In particular, we are unable to acquire imaging from the military facilities.

It is important that we obtain a copy of **your identification and insurance cards** at the time of your visit. Also, if your insurance requires a referral from your primary care physician, you will need to bring that with you. **Co-payments, co-insurance and deductibles are to be paid at the time of service**, unless previous arrangements have been made (cash, check, and credit cards accepted). We bill your insurance carrier as a courtesy to you. You are responsible for what your insurance does not cover.

Again, we look forward to meeting you and helping you with your medical condition.

Sincerely,

Cardiac & Thoracic Surgery Associates
Office Staff

Cardiac & Thoracic Surgery Associates **Date Completed:_____**

Patient Information

Name: _____ Birth Date: _____
Last First Middle Initial

Address:

_____
Street City State Zip

Address: ❑ Same as above _____
(Mailing) Street City State Zip

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email Address: _____ May we contact you by email? ❑ Yes ❑ No

SSN: _____ ❑ Male ❑ Female **Preferred language to discuss medical care: _____**

Race: ❑ Caucasian ❑ African American ❑ Hispanic ❑ Native American ❑ Asian ❑_____

Employer: _____ Employer Address: _____Occupation:_____

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Unemployed ❑ Student ❑ Retired

Emergency Contact: Name:_____ Relationship: _____

Phone: _____ Alternate Phone: _____

Spouse/Parent Name: _____ Phone:_____

Do you have Advance Directives (Living Will, Power of Attorney)? ❑ Yes ❑ No

Preferred method of contact: ❑ Phone ❑ Mail ❑ Email

Spouse/Parent Name: _____ Address and Phone:_____

Insurance Information

Primary Insurance: _____ID#:_____GRP #: _____

Insured's Name:_____ SSN:_____ Birth Date: _____ Relationship: _____

Co-pay (specialty office visit): _____

Secondary Insurance: _____ID#:_____GRP #: _____

Insured's Name:_____ SSN:_____ Birth Date: _____ Relationship: _____

❑ I do not have secondary insurance

Medical Information

Reason for Visit:_____

Referring Doctor: _____ **Phone:** _____**Fax:** _____

Other Doctors Treating You

Primary Doctor: _____ **Phone:** _____**Fax:** _____

Cardiologist: _____ **Phone:** _____**Fax:** _____

Pulmonary (Lung): _____ **Phone:** _____**Fax:** _____

Oncologist: _____ **Phone:** _____**Fax:** _____

Other Doctor: _____ **Phone:** _____**Fax:** _____

Social History:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

With Whom Do You Live: ❑ Alone ❑ Children ❑ Parent(s) ❑ Spouse/Partner ❑ Other: _____

Religious Preference: _____❑None

Education: ❑ Primary School ❑ High School ❑ College ❑ Graduate School ❑ Other ___

Have you ever used tobacco? ❑ Yes ❑ No Quit Date: _____

If yes: Type:	Amount per day:	For how many years:
❑ Cigarettes	_____pack(s)	_____
❑ Cigars	_____cigars	_____
❑ Tobacco	_____pipes or chew	_____

Have you ever used alcohol? ❑ Yes ❑ No Quit Date: _____

If yes: Type	Frequency	Amount per week
❑ Beer	❑Daily ❑Weekends ❑Rare	_____cans/week
❑ Wine	❑Daily ❑Weekends ❑Rare	_____glasses/week
❑ Liquor	❑Daily ❑Weekends ❑Rare	_____shots/week

Have you ever used illegal substances? ❑ Yes ❑ No Quit Date: _____

If yes: Type: _____

Do you have other chemical exposures? ❑ Yes ❑ No

If yes, please describe:_____

How often do you exercise? ❑Never ❑ More than 20 minutes ❑ More than 4 times a week

Do you have difficulty performing independent activities of daily living, such as bathing, medications, ambulating, etc? ❑ Yes ❑ No

Do you feel safe at home? ❑ Yes ❑ No

Do you have a support network? ❑ Yes ❑ No

Health Questionnaire

PAST MEDICAL HISTORY

Please check if you currently have or previously had any of the conditions below

Fibromyalgia	❑ Yes ❑ No	Diverticulitis	❑ Yes ❑ No
Steroid Use	❑ Yes ❑ No	GI Bleeding	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Irritable Bowel Syndrome	❑ Yes ❑ No
Hyperthyroidism	❑ Yes ❑ No	Inflammatory Bowel Disease	❑ Yes ❑ No
Hypothyroidism	❑ Yes ❑ No	Liver Disease or Hepatitis	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Peptic Ulcer	❑ Yes ❑ No
Bronchitis/Pneumonia	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Kidney Stones	❑ Yes ❑ No
Home Oxygen Use	❑ Yes ❑ No	Urinary Tract Infection	❑ Yes ❑ No
Tuberculosis	❑ Yes ❑ No	Osteoarthritis	❑ Yes ❑ No
Sleep Apnea	❑ Yes ❑ No	Osteopenia/Osteoporosis	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Rheumatoid Arthritis	❑ Yes ❑ No
Heart Failure	❑ Yes ❑ No	Lupus or Connective Tissue Disorder	❑ Yes ❑ No
High Cholesterol	❑ Yes ❑ No	Anemia	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	Bleeding Disorder	❑ Yes ❑ No
Heart Attack	❑ Yes ❑ No	Cancer, type: _____	❑ Yes ❑ No
Arrhythmias (Irregular heartbeat)	❑ Yes ❑ No	HIV/AIDS	❑ Yes ❑ No
Pacemaker	❑ Yes ❑ No	Headaches or Migraines	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Paralysis	❑ Yes ❑ No
Heart Disease	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	Eating Disorder	❑ Yes ❑ No
Blood clot	❑ Yes ❑ No	Anxiety	❑ Yes ❑ No
Peripheral Vascular Disease	❑ Yes ❑ No	Depression	❑ Yes ❑ No
Acid Reflux	❑ Yes ❑ No	Head Injury	❑ Yes ❑ No

Other medical conditions not listed above:_____

Year	Surgery/Procedure	Hospital

❑ **I have never had surgery**

FAMILY HISTORY

Are you adopted? ❑ Yes ❑ No

Please list all immediate family members (parents, siblings, and children)

Relation	Age	Health Status	If deceased, age and cause of death

Please list all relatives who have had any type of cancer ❑ **None known**

Relation	Maternal	Paternal	Type of cancer	Age at diagnosis	Outcome

Please list any other diseases/conditions that run in the family ❑ **None known**

Relation	Maternal	Paternal	Disease/Condition	Age at diagnosis

Do you <u>currently</u> experience any of the problems or illnesses listed below? If so, please explain.

<u>Constitutional (General)</u>
- ❑ Fatigue
- ❑ Fever
- ❑ Insomnia
- ❑ Weight Gain in Last 3 Months: Amount: ____# of Months: ___
- ❑ Weight Loss in Last 3 Months: Amount: ____# of Months: ___
- ❑ Chills
- ❑ Other: _____

<u>Eyes</u>
- ❑ Blurred Vision
- ❑ Eye Pain
- ❑ Spots in Vision
- ❑ Vision Loss
- ❑ Double Vision
- ❑ Other: _____

<u>Ears, Nose, Mouth, Throat</u>
- ❑ Ringing in the Ears
- ❑ Vertigo
- ❑ Nose Bleeds
- ❑ Hoarseness
- ❑ Sore Throat
- ❑ Other: _____

<u>Cardiovascular</u>
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Syncope
- ❑ Leg Pain with Walking
- ❑ Leg Swelling
- ❑ Discoloration of Fingers or Toes
- ❑ Varicose Veins
- ❑ Stroke
- ❑ Heart Attack
- ❑ Congestive Heart Failure
- ❑ High Blood Pressure
- ❑ Chest Wall Surgery
- ❑ Vena Cava Umbrella or Filter
- ❑ Atrial Fibrillation
- ❑ Pacemaker <u>Brand:</u>_____
- ❑ AICD <u>Brand:</u>_____
- ❑ Other: _____

<u>Respiratory</u>
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ Snoring
- ❑ Sleep Apnea
- ❑ Emphysema/COPD
- ❑ Asthma
- ❑ Other: _____

<u>Gastrointestinal</u>
- ❑ Abdominal Pain
- ❑ Nausea or Vomiting
- ❑ Reflux/Heartburn
- ❑ Constipation
- ❑ Bloody Stools
- ❑ Stomach Ulcers
- ❑ Jaundice/Hepatitis
- ❑ Other: _____

<u>Genitourinary</u>
- ❑ Dysuria (Painful urination)
- ❑ Incontinence
- ❑ Urinary Frequency
- ❑ Abnormal Vaginal Bleeding
- ❑ Postmenopausal
- ❑ Other: _____

<u>Musculoskeletal</u>
- ❑ Pain: Back, Joint, Neck
- ❑ Limited Range of Motion
- ❑ Muscle Cramps
- ❑ Muscle Weakness
- ❑ Arthritis/Gout
- ❑ Broken Bones
- ❑ Other: _____

<u>Integumentary</u>
- ❑ Rash
- ❑ Persistent Itch
- ❑ Breast Masses
- ❑ Other: _____

<u>Neurologic</u>
- ❑ Headache
- ❑ Memory Problems
- ❑ Numbness
- ❑ Poor Balance
- ❑ Tremor
- ❑ Dizziness
- ❑ Seizures
- ❑ Migraines
- ❑ Other: _____

<u>Psychiatric</u>
- ❑ Anxiety
- ❑ Sleep Disturbances
- ❑ Sadness/Tearfulness
- ❑ Depression
- ❑ Considered Suicide
- ❑ Generally satisfied with your life
- ❑ Other: _____

<u>Endocrine</u>
- ❑ Cold or Heat Intolerance
- ❑ Tired/Sluggish
- ❑ Diabetes
- ❑ Increased Cholesterol
- ❑ Kidney Disease or Stones
- ❑ Thyroid Disease
- ❑ Gallbladder Disease or Stones
- ❑ Other: _____

<u>Hematologic/Lymphatic</u>
- ❑ Bruising
- ❑ Bleeding Tendencies
- ❑ Swollen Glands
- ❑ Blood Clotting Problem
- ❑ Blood Clots in Veins
- ❑ HIV/AIDS
- ❑ Anemia
- ❑ Other: _____

<u>Allergic/Immunologic</u>
- ❑ Eczema
- ❑ Other: _____

Medication List: Please list all of the medications that you take including the dose and schedule, **including Aspirin, vitamins and supplements** (or attach complete list):

Start Date	Medication	Dosage	Frequency

Are you currently taking: Aspirin: ❑Yes ❑No Coumadin: ❑Yes ❑No Pradaxa: ❑Yes ❑No
Vitamin E: ❑Yes ❑No Fish Oil: ❑Yes ❑No Plavix: ❑Yes ❑No

Allergies:

Are you allergic to any medications? ❑ Yes ❑ No Known Allergies

Please list any food, drug, or seasonal allergies:

1._____Type of Reaction:_____ 5._____Type of Reaction:_____
2._____Type of Reaction:_____ 6._____Type of Reaction:_____
3._____Type of Reaction:_____ 7._____Type of Reaction:_____
4._____Type of Reaction:_____ 8._____Type of Reaction:_____

Preferred Pharmacy Name: _____ Pharmacy Phone Number: _____

Address (or cross streets): _____

Will you accept blood products if it is medically necessary? ❑ Yes ❑ No

Phone Message or Fax Consent

Cardiac & Thoracic Surgery Associates, at times, may need to contact you about test results, appointments, referrals or billing/insurance information. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed a policy on leaving medical care messages. Unless we have written permission to do so:

1. **We will not leave messages with anyone except the patient or legal guardian.**
2. **We will not leave messages on voicemail or answering machines.**
3. **We will not send faxes.**

Please read below and carefully consider who, if anyone, you want to have access to your medical/account information.

I, _____, give my permission for Cardiac & Thoracic Surgery Associates to leave phone messages and/or fax messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

Do we have your permission to: Call you at home? ❑ Yes ❑ No Call you at work? ❑ Yes ❑ No

Can we leave the following information on your home answering machine or voicemail?

Appointment Information ❑ Yes ❑ No

Billing Information ❑ Yes ❑ No

Medical Information ❑ Yes ❑ No

Can we leave the following information on your work answering machine or voicemail?

Appointment Information ❑ Yes ❑ No

Billing Information ❑ Yes ❑ No

Medical Information ❑ Yes ❑ No

I give my permission to share the following information with the person(s) listed below, if none are listed no information will be released:

Name: _____Relationship:_____ Phone: _____

Appointment: ❑ Yes ❑ No Billing: ❑ Yes ❑ No Medical: ❑ Yes ❑ No

Name: _____Relationship:_____ Phone: _____

Appointment: ❑ Yes ❑ No Billing: ❑ Yes ❑ No Medical: ❑ Yes ❑ No

Name: _____Relationship:_____ Phone: _____

Appointment: ❑ Yes ❑ No Billing: ❑ Yes ❑ No Medical: ❑ Yes ❑ No

Name: _____Relationship:_____ Phone: _____

Appointment: ❑ Yes ❑ No Billing: ❑ Yes ❑ No Medical: ❑ Yes ❑ No

Special Instructions, if any: _____

Signature: _____ Date:_____

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Cardiac & Thoracic Surgery Associates, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send you a recall card in the mail. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail our files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for information or assistance regarding your health information privacy, please contact our Privacy Officer, Kathy Camasta or if not available, Kelly Henson at (719) 776-7600. This notice has been revised November 12, 2011.

Cardiac & Thoracic Surgery Associates

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge Cardiac & Thoracic Surgery Associates privacy practice

and understand that I may request a copy of the privacy practice.

_____ _____

Signature of patient or patient representative **Date**

Documentation of Good Faith Efforts

(For use when acknowledgement cannot be obtained from the patient)

The patient presented to the office on _____ and was notified of the Covered Entity's Notice of Privacy Practice. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the notice.

____ Patient refused to sign

____ Patient was unable to sign or initial because: _____

_____

____ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

____ Other reason (describe below): _____

_____

_____