

**NEW PATIENT HEALTH STATUS / HISTORY SURVEY**

**PERSONAL DATA**

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ Initial \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Marital Status: S M W D                      Gender: M F  
 Phone (\_\_\_\_\_) \_\_\_\_\_  
 Work Phone(\_\_\_\_\_) \_\_\_\_\_  
 Family Physician \_\_\_\_\_  
 Employer \_\_\_\_\_

**INSURANCE INFORMATION**

**1st Insurance** \_\_\_\_\_  
 Subscriber's S.S. # \_\_\_\_\_  
 Group No. \_\_\_\_\_  
 Ins. Phone No. \_\_\_\_\_  
**2nd Insurance** \_\_\_\_\_  
 Subscriber's S.S. # \_\_\_\_\_  
 Group No. \_\_\_\_\_  
 Ins. Phone No. \_\_\_\_\_

**ALLERGIES**

Iodine                       Shellfish

**FAMILY HISTORY**

*please check if your parent or sibling has ever had:*

- Stroke
- Diabetes
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Coronary bypass surgery
- Other \_\_\_\_\_

**SYMPTOMS**

- Ankle / feet swelling
- Bruising easily
- Chest pain / discomfort
- Cough (productive) \_\_\_\_\_ with blood
- Dizziness / fainting
- Fever
- Leg cramping with exercise
- Palpitations
- Shortness of breath
- Weakness
- Weight Loss

**YOUR PERSONAL MEDICAL HISTORY**

- Anemia
- Anxiety / Depression
- Arthritis
- Asthma
- Cancer date(s) \_\_\_\_\_
- Emphysema
- Hepatitis type \_\_\_\_\_
- Seizures
- Stroke date(s) \_\_\_\_\_
- Thyroid problem
- Tuberculosis
- Ulcer

**YOUR CARDIAC HISTORY**

- Angioplasty date(s) \_\_\_\_\_
- Cardioversion date(s) \_\_\_\_\_
- Carotid Surgery date(s) \_\_\_\_\_
- Cardiac Catheterization date(s) \_\_\_\_\_
- Coronary bypass surgery date(s) \_\_\_\_\_
- Enlarged heart
- Heart attack date(s) \_\_\_\_\_
- Heart failure
- Heart murmur
- ICD date(s) \_\_\_\_\_
- Pacemaker date(s) \_\_\_\_\_
- Valve surgery date(s) \_\_\_\_\_

**RISK FACTORS**

- Alcohol consumption \_\_\_\_\_ drinks/week
- Diabetes \_\_\_\_\_ yrs.
- Exercise \_\_\_\_\_ times per week  
type: \_\_\_\_\_
- High cholesterol  
total \_\_\_\_\_ HDL \_\_\_\_\_ LDL
- High blood pressure \_\_\_\_\_ yrs.
- Low fat / low cholesterol diet
- Current Smoker \_\_\_\_\_ yrs., \_\_\_\_\_ pks./day
- Past Smoker \_\_\_\_\_ yrs.  
\_\_\_\_\_ packs per day, \_\_\_\_\_ year quit

**Patient Signature**

**Date**

**Physician Signature**

**Date**

# NEW PATIENT MEDICATION INFORMATION

MICHIGAN HEART  
RHYTHM GROUP

WESTERN WAYNE  
HEART GROUP

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

PHARMACY PHONE: \_\_\_\_\_

To assist the physicians and practitioners with your future medical evaluations, please list all current medications that you are taking. Include the name of the medication, the dosage, how many pills you take and how many times per day you take it, and whether your medications are called in to a local pharmacy for refills or obtained by mail order. Thank you for your assistance.

MEDICATION NAME	DOSAGE (mg)	HOW OFTEN TAKEN	TYPE OF ORDER (circle one)	COMMENTS
ex. Norvasc	10 mg	1 tablet, three times a day	local pharmacy / mail order	
1			local pharmacy / mail order	
2			local pharmacy / mail order	
3			local pharmacy / mail order	
4			local pharmacy / mail order	
5			local pharmacy / mail order	
6			local pharmacy / mail order	
7			local pharmacy / mail order	
8			local pharmacy / mail order	
9			local pharmacy / mail order	
10			local pharmacy / mail order	
11			local pharmacy / mail order	
12			local pharmacy / mail order	
13			local pharmacy / mail order	

Please list any medication allergies \_\_\_\_\_

**Michigan Heart Group  
Michigan Heart Rhythm Group  
Western Wayne Heart Group**

**Authorization for Release of Information**

Dear Patient:

Your medical information is the property of the physician or facility in which the information was obtained. To release your information from one physician to another you must fill out this form completely. New patients to Michigan Heart Group must have presented Michigan Heart Group with previous medical information from either a referring physician or family physician prior to their first appointment. **NEW PATIENTS THAT DO NOT OBTAIN THEIR MEDICAL INFORMATION PRIOR TO THEIR FIRST VISIT AND SHOW UP FOR THEIR APPOINTMENT WITHOUT THIS INFORMATION WILL BE RESCHEDULED.** It is vital that your Michigan Heart Group physician have copies of your previous medical history in order to properly serve you. If you have questions regarding your medical information please contact our Health Information Department at (248) 267-9062. Please mail, fax or deliver this completed form to the physician's office or hospital that you are requesting record from. Authorization forms can be faxed to us at 248-267-9076

Name

Address

Date of Birth

Phone #

S.S.#

I authorize Michigan Heart Group to OBTAIN my medical records FROM:

I authorize Michigan Heart Group to SEND my medical records TO:

\_\_\_\_\_  
Name of Physician or Facility

\_\_\_\_\_  
Name of Physician or Facility

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone & Fax #

\_\_\_\_\_  
Phone & Fax #

For the purpose of:      ( ) Continued Medical Care      ( ) Personal Use

**THE EXACT INFORMATION TO BE RELEASED SHOULD INCLUDE:**

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

\_\_\_\_\_  
Patient Name (PRINT)

\_\_\_\_\_  
Patient/Representative Signature

\_\_\_\_\_  
Date

*This authorization will expire ninety days after date of signature. A photocopy of this authorization shall have the same effect as the original.*

**Notice To Receipt**

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 C.F.R., Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

**MICHIGAN HEART GROUP, P.C. FINANCIAL POLICY**

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

**CO-PAY/DEDUCTIBLE PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE.**

**NON-INSURED PATIENTS WILL NEED TO EITHER ARRANGE A PAYMENT PLAN IN ADVANCE OF APPOINTMENTS OR PAY IN FULL AT THE TIME OF SERVICE.**

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. We accept cash, personal checks, VISA, and MasterCard.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling further appointments. If payment arrangements are not being adhered to you may be terminated from the practice. We realize that financial difficulty is a reality. In such circumstances, we may advise you to seek your healthcare through a clinic or health bureau.

**INSURANCE:**

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

**MISSED APPOINTMENTS/LATE CANCELLATIONS:**

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the **Michigan Heart Group** Financial Policy. I agree to assign insurance benefits to **Michigan Heart Group** whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or authorized representative:

\_\_\_\_\_

Date: \_\_\_\_\_

Pt. # \_\_\_\_\_

