RED MOUNTAIN CARDIOTHORACIC SURGEONS
PATIENT REGISTRATION

Phone: 480-782-6900 Fax: 480-782-6905

(Please print clearly and complete ALL information)

Patient Information

Last Name ______________________________ First Name ______________________________

Middle name ____

Address ____

Zip ______________ City ______________________________________ State ______________

Telephone (Primary) ____________________ (Cell) ____________________ (Work) ____________________

Date of Birth ______________ Sex ________ SS# ______________________________

Email address: ____

Relationship to Guarantor: Self ________ Spouse ________ Child ________ Other ____________

Marital Status: S M W D Spouse's Name ____________________ Student? F/T P/T Employed? F/T P/T Retired Not

Family Doctor (**PCP**) ____________________________ Referred by ______________________________

Pharmacy ____

Emergency Contact __________________________ Phone Number ______________________

May we leave a voicemail with medical information? Yes/No

Guarantor Information (Person Responsible for Payment)

Last Name ______________________________ First Name ______________________ M.I. ________

Address ____

Zip ______________ City ______________________________________ State ______________

Telephone (Home) ____________________ (Work) ____________________ SS# ____________________

Guarantor's Employer ____

Employer's Address ____

Insurance Information

Primary Insurance Company __________________________________ Phone ______________________

Address ____________________________________ City ____________ State ________ Zip ________

Policy Holder: Name ______________________ Employer ____________________ D.O.B. __________ Sex ________

Patient's Rel. to Policy Holder ____________________ other covered family members ____________________

Group Number ____________________ Policy ID Number ______________________ Eff. Date ________

Deductible ______________ Co-payment ______________ % Ins. Pmt. ______________________

Secondary Insurance Company __________________________________ Phone ______________________

Address ____________________________________ City ____________ State ________ Zip ________

Policy Holder: Name ______________________ Employer ____________________ D.O.B. __________ Sex ________

Patient's Rel. to Policy Holder ____________________ other covered family members ____________________

Group Number ____________________ Policy ID Number ______________________ Eff. Date ________

Deductible ______________ Co-payment ______________ % Ins. Pmt. ______________________

I hereby give permission to treat me or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but that I am ultimately responsible for all medical services rendered, and if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have.

I authorize the release of any medical information necessary to process the claim to my insurance company. I furthermore authorize payment of medical benefits directly to my physician for services rendered.

Signature ____ Date ______________________

Red Mountain Cardiothoracic Surgeons

Iva A. Smolens, MD   Michael C. Maxwell, MD

NAME: ______________________________ Birth Date: _____/_____/______________

WHY ARE YOU HERE TODAY? ____

MEDICAL HISTORY

HIGH BLOOD PRESSURE	YES	NO	______________________________
HEART DISEASE	YES	NO	______________________________
ASTHMA/EMPHYSEMA	YES	NO	______________________________
DIABETES	YES	NO	______________________________
STROKE	YES	NO	______________________________
CIRCULATION PROBLEMS	YES	NO	______________________________
KIDNEY PROBLEMS	YES	NO	______________________________
CANCER	YES	NO	______________________________
BLEEDING DISORDERS	YES	NO	______________________________
VALLEY FEVER/TB	YES	NO	______________________________
OTHER PROBLEMS	YES	NO	______________________________
			______________________________
			______________________________
			______________________________

PRIOR SURGERIES/PROCEDURES

OPEN HEART SURGERY	YES	NO	__________________	DATE__________
CARDIAC STENTS	YES	NO	__________________	DATE__________
LUNG SURGERY	YES	NO	__________________	DATE__________
VASCULAR SURGERY	YES	NO	__________________	DATE__________
CANCER SURGERY	YES	NO	__________________	DATE__________
ORTHOPEDIC SURGERY	YES	NO	__________________	DATE__________
OTHER SURGERY	YES	NO	______________________________	
			______________________________	
			______________________________	

SOCIAL HISTORY

DO YOU WORK?	YES	NO	OCCUPATION______________________________
DO YOU LIVE ALONE?	YES	NO	WITH WHOM______________________________
TRAVEL LAST 6 MOS OUTSIDE THE U.S.?	YES	NO	WHERE______________________________

DO YOU SMOKE TOBACCO? Never/quit long ago/quit recently/current <1PPD/1-2PPD/>2 PPD

DO YOU DRINK ALCOHOL? Never/quit long ago/quit recently/current social/current daily

DO YOU USE DRUGS? Never/quit long ago/quit recently/occasionally/too much

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY EVER HAD:

HEART DISEASE	YES	NO	WHOM ________
ANEURYSM	YES	NO	WHOM ________
DIABETES	YES	NO	WHOM ________
INFECTIOUS DISEASE	YES	NO	WHOM/TYPE OF ________
STROKE	YES	NO	WHOM ________
CANCER	YES	NO	WHOM/TYPE OF ________
VENOUS VARICES	YES	NO	WHOM ________
BLOOD COAGULATION DISORDER	YES	NO	WHOM ________

CURRENT MEDICATIONS:

NAME	DOSE IN MG	TIMES/DAY	NAME	DOSE IN MG	TIMES/DAY

ALLERGIES TO MEDICATIONS

☐ NO KNOWN DRUG ALLERGIES

DRUG NAME:________ REACTION:________
DRUG NAME:________ REACTION:________
DRUG NAME:________ REACTION:________
DRUG NAME:________ REACTION:________

RED MOUNTAIN CARDIOTHORACIC SURGEONS
REVIEW OF SYSTEMS

Patient Name: ______________________________ **Date of Birth:** ________

Do you now, or have you ever had, any of the problems related to the following systems? Circle Yes or No.

GENERAL

Significant weight loss/gain	Y	N
Night sweats	Y	N
Unexplained fever	Y	N
Exercise intolerance	Y	N

EYES

Dry eyes/irritation	Y	N
Vision change	Y	N

ENT

Difficulty hearing	Y	N
Frequent nosebleeds	Y	N
Sore throat	Y	N
Bleeding gums	Y	N
Oral abnormalities	Y	N

CARDIOVASCULAR

Chest pain	Y	N
Palpitations	Y	N
Known heart murmur	Y	N
Light-headed on standing	Y	N

RESPIRATORY

Cough	Y	N
Wheezing	Y	N
Shortness of breath	Y	N
Coughing up blood	Y	N
Sleep apnea	Y	N

GASTROINTESTINAL

Abdominal pain	Y	N
Vomiting	Y	N
Change in appetite	Y	N
Black/tarry stools	Y	N
Frequent diarrhea	Y	N
Vomiting blood	Y	N

GENITOURINARY

Incontinence	Y	N
Difficulty urinating	Y	N
Blood in urine	Y	N

MUSCULOSKELETAL

Muscle aches	Y	N
Muscle weakness	Y	N
Joint pain	Y	N
Back pain	Y	N
Swelling in extremities	Y	N

NEUROLOGIC

Loss of consciousness	Y	N
Weakness/numbness	Y	N
Seizures	Y	N
Dizziness	Y	N
Frequent headaches	Y	N
Migraines	Y	N

PSYCHIATRIC

Depression	Y	N
Sleep disturbances	Y	N
Alcohol abuse	Y	N

HEMATOLOGIC/LYMPHATIC

Swollen Glands	Y	N
Easy bruising	Y	N
Excessive bleeding	Y	N

RED MOUNTAIN CARDIOTHORACIC SURGEONS

Acknowledgement of receipt of notice of privacy practices

I acknowledge that I received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

Printed Patient Name ____________________ Name/Relationship if signed by Individual other than patient ____________________

Signature ____________________ Date ____________________

PATIENT RECORD OF DISCLOSURES

The HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of personal health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as correspondence of home.

Emergency Contact

Name____________________Phone number____________________

May we speak to your emergency contact if he/she contacts us on your behalf? Yes/No

Please list names and phone numbers of those individuals involved in your care / whom you will allow us to share your health and treatment information-including family members and friends(If none put N/A)

Name: Phone:

Relationship

Name: Phone:

Relationship