TODAY'S DATE:_______________

PATIENT DEMOGRAPHICS

Last Name ___________________________ First Name _____________________________ Middle Name ________________

Date of Birth ______/______/_______ Social Security Number ________-________-________ Male: ☐ Female ☐

Home #: _______-___________-___________ Cell #: _______-___________-____________

Home Address: ____ City______________ State_________ Zip: _______

Email: ____

Marital Status: Married☐ Single☐ Divorced☐ Separated☐ Widowed☐ Other☐

Appointment Reminder preference (you can pick more than one method)	Text: ☐	E-mail: ☐	Call/Leave message: ☐

PERSONAL INFORMATION

Employer: ____ Occupation: ___________________________________

Work Address: ____City, State, Zip: ___________________________________

Work Phone: _____________________________________ Ext: ____________________ May Contact: ________Y _________N

Emergency Contact: ____

Phone: ____________________________________ Relationship to Patient: ____

If you become unable to handle your finances, who will be responsible: ____
____

Who referred you to our office? : ____ Phone: _________________________

Who is your primary care physician: ____ Phone: _________________________
(Include first AND last name of Physician)

INSURANCE INFORMATION

Primary Insurance: ____ Insurance ID #: ___________________________________

Secondary Insurance: _______________________________________ Insurance ID #: ___________________________________

Listed below are people allowed to receive /share my medical information?

Name: __________________________________ Relationship: ___________________ Phone Number: ____________________

Name: __________________________________ Relationship: ___________________ Phone Number: ____________________

Financial Policy

Initial

__ I understand that my insurance policy serves as a contractual agreement between me and my insurance provider. I am accountable for familiarizing myself with my plan and ensuring the accurate provision of insurance information.

__ I will provide Co-Pay, Coinsurance, and deductibles at the time services are rendered. As a convenience to me, "State of the Heart" will prepare and send the insurance claim to my insurance company for direct payment remittance to them.

__ If, under any circumstances, my insurance company issues partial payment or does not make payment within a reasonable timeframe, I will assume full responsibility for the outstanding balances not covered by the insurance policy.

__ If my coverage is under a plan that Dr. Gupta is not in-network with the insurance company might send the payment directly to me. As a result, I agree to provide payment for the services at the time they are rendered.

__ If I need to cancel or reschedule my appointment, I will contact the offices at least 24 hours before my appointment. I acknowledge and accept the no-show/cancellation policy, which incurs a fee of $50.00 for any missed appointment or no-show, in the event that I neglect to notify and cancel within 24 hours of my scheduled appointment time.

Patient's Full Name (Print) : ____

Patient's Signature: _______________________________________ Date__________________

CONSENT FOR TREATMENT

I hereby consent to and authorize administration and performance of all the examinations, in the judgment of Manish Gupta M.D. may be considered advisable for my diagnosis and treatment. I hereby authorized Manish Gupta M.D. to release necessary medical information to complete any insurance forms/third party payments forms which may be submitted in connections with my treatment.

I have read and understand the practice financial policy and agree to be bound by its terms. I also understand that such terms may be amended by the practice from time to time.

Patient's Full Name (Print): ____

Patient's Signature: _____________________________ Date: ______________

PATIENT RIGHTS AND RESPONSIBILITIES

The following list of the right and responsibilities does not presume to be all inclusive, but is intended to show our concern for you and to emphasize the need for observance of these rights and responsibilities.

- Considerate and respectful care provided in a safe environment, free all forms of abuse, harassment or discrimination.
- Participate in the development and implementation of your plan of care and actively participate in decisions regarding your medical care. To the extent permitted by the law, this includes the right to request and or refuse treatment.
- Be well informed about your illness, possible treatments, and likely outcome of care. (Including anticipated outcome) and to discuss this information is urgent. The information is made available to another person on your behalf.
- Upon your request, your family member, chosen reprehensive and or your own
- Not undergo any procedure unless you or your legally authorized representative gives voluntary, competent a understanding consent.
- Remain free form seclusions and restraints of any form that are not medically necessary or used as a means of coercion, discipline, convenience or retaliation by staff.
- Expect that those providing care will protect your privacy and support your personal dignity.
- Have your cultural, psychosocial, spiritual and personal values, beliefs and preference respected.
- Expect that treatment records are confidential unless you have given permission to release information or reporting is required or permitted by the law. When the hospital releases your records to others, such as insures, it emphasizes that the records are confidential.
- Review your own medical records and to have the information explained within a reasonable amount of time except when restricted by law.
- Expect that State of the Heart will make a reasonable response to the best of the ability to a patient's request for medically indicate care. Treatment, referral or referral or transfer may be recommended. If transfer is recommended or requested, you will be informed of risks, benefits, alternatives. You will not be transferred until the other institution agrees to accept.
- Know the name of the physician who has primary responsibility for coordinating your care and if State of the Heart has relationship with outside parties that may influence your treatment and care.
- Be told of alternative when hospital is no longer appropriate
- Be informed by your physician of the continuing healthcare requirements following your discharged from the hospital.
- Access to an interpreter or translator if necessary
- Expect that medical information is done in accordance or disclosure about you and your right and our obligations to the use and disclosure of your medical information is done with our notice of privacy.
- Access request amendment to and receive an accounting of disclosure regarding his/her own health information as permitted under applicable law.

Patient Signature: ____ Date: __________________________

PATIENT PROFILE AND MEDICAL HISTORY

Height________ Weight__________

Allergies to any medications? Y / N
____
__High Blood Pressure
__High Cholesterol or Triglycerides
__Heart Attack if yes, when? __/__/__
__Peripheral Vascular Disease
__Heart Murmur
__Aortic or Mitral Valve Disease
__Congestive Heart Failure
__Rheumatic Fever / Scarlet Fever
__Stroke / TIA If yes when? __/__/__
__Asthma
__Emphysema/COPD (Lung Disease)
__Seizures
__Diabetes (NIDDM/IDDM)
__Gout
__Cancer> Type? ______________________
__Kidney / Urinary Problems
__Thyroid Disorder
__Hiatal Hernia / GERD
__Ulcers> Stomach or other? ___________
__AIDS / HIV
Please List any major operations/surgeries:
____
____
list Hospitals /Dates where you have
Hospitalized in the past year? ___________
____
____
____
____
____
____

Do you Smoke? Y / N
If yes, how much daily? __________________
Started? __/__/__ Quit? __/__/__
Weekly alcohol consumption_____________
Daily Caffeinated beverage______________
Exercise? Y / N if so how often? _________
Have you illicit drugs? Y / N

WOMEN

Are you taking oral contraceptives? Y / N
Pregnant or planning pregnancy? Y /N
Are you menopausal? Y /N
Have you had a hysterectomy? Y /N

MEN

Have you had prostate problems? Y / N

FAMILY HISTORY

__Stroke __Heart Attack __Diabetes
__Sudden Death __High Cholesterol
__Cancer __High Blood Pressure

*** Have you had the following:**

__ Treadmill or Exercise Test __/__/__
__Heart Catheterization __/__/__
__Angioplasty (Balloon) __/__/__
__Blood vessel/Valve Surgery __/__/__
__Pacemaker Implanted __/__/__

***Experiencing the following symptoms:** Please
__ Shortness of breath __ Abdominal Dis.
__Edema (Swollen Legs, ankles, feet)
__Cough/Phlegm/Hemoptysis/fever
__Dizziness? Presyncope
__Chest Pain/Pressure/Discomfort
__Irregular Heartbeats or Palpitations
__Bruise/Blees Easily __leg Pains w/Walking
__Heartburns __Nausea/Vomiting

PATIENT MEDICATION LIST

Please review the medications list and confirm that you are currently taking these medications.
Please make changes or additions as needed.

Medications:	Dosage:	Times Per Day:

Pharmacy Information

Pharmacy Name:_____________________________________

Phone Number: ______________________________________

Address: ____

AUTHORIZATION TO RELEASE RECORDS

Patient Name: ____ DOB: ____________________
I hereby authorize :____

Health Information to be disclosed: (Check appropriate line)

__ 2 years prior from last date seen by my healthcare provider
__ The following Health Information (Be Specific)

Release Medical Records To:
State of the Heart
Manish Gupta MD, FACC, FSCAI
6090 South Fort Apache #130
Las Vegas NV 89148
Phone: (702)-321-1513
Fax: (702)-475-4591

The information is being disclosed for the following purpose: (check appropriate line)

__ Change of Insurance or physician __ Continuation of Care

- I understand I may revoke this authorization at any time by sending written notice of my revocation to NP'S health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken actions in reliance on this authorization. Unless revoked sooner, this authorization will expire on the following date, event or conditions: If no date, event, or condition is written, this authorization will expire 1 year from the date signed. A photocopy of this authorization will be considered effective and valid as the original.
- I understand that the health information authorized to be disclosed under this authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis, or treatment for HIV, HIV related diseases and communicable disease –related information.
- I understand that NP may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the recipient may re disclose the records and that the records may no longer be protected by the federal privacy regulations.

___________________________________ ____________________

Signature of the Patient/ Parent/ Guardian Date