PATIENT INFORMATION

Date: ____________________

Name: ____ **Sex: M/ F Date of Birth**______________ **(mm/dd/yr.)**

Social Security #_________/_________/_________ **Email:** ____

Home: (_____) __________________ **Cell: (_____)** __________________ **Work: (_____)** __________________

What is the best way to reach you? ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone** ☐ **E-mail** ☐ **Text**

Do you prefer: ☐ **Detailed message** ☐ **Brief message**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow** ☐ **Partner**

Do you have an Advanced Directive? Yes / No.

Home Address: ____ **Apt. #** _____________

City: ___________________________ **State:** __________ **Zip Code:** _________________

Billing Address (If different than home address): ____

City: ________________**State:** ______ **Zip Code:** ______________

Race: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Native Hawaiian or Other Pacific Islander**
☐ **Black or African American** ☐ **White/Caucasian** ☐ **Other** ☐ **I choose not to provide this**

Ethnicity: ☐ **Hispanic or Latin** ☐ **Not Hispanic or Latino** **Primary Language:** _________________

Employer: ____ ☐ **Retired** **Self Employed:** ☐ **Yes** ☐ **No**

Work Address: ____________________________ **City:** __________ **State:** ____ **Zip Code:** __________________

Emergency Contact: __________________________**Relationship:** ______________**Phone:**________________

Who is your Primary doctor (PCP)? _______________________________ **Phone:** ________________________

Who is the referring Doctor? Name _______________________________**Phone:** ________________________

*** By providing your email, you are providing permission for us to email you with educational information. We never sell, or share, your email address with anyone outside of Ameli | Dadourian Heart Center.**

How did you hear about Ameli | Dadourian Heart Center?

☐ Physician ☐ Insurance Plan ☐ Hospital ☐ Close to home/work

☐ Family ☐ Friend ☐ Other ☐ Marketing Source______________________

INSURANCE INFORMATION:

Primary Insurance: ______________________ Insured: ☐ Self ☐ Spouse ☐ Other

Subscriber: ________________ Date of Birth: ________ Policy or ID#: ____________________

Group#: ________________ Social Security #: ______ / ______ / ______

Secondary Insurance: ______________________ Insured: ☐ Self ☐ Spouse ☐ Other

Subscriber: ________________ Date of Birth: ________ Policy or ID#: ____________________

Group#: ________________ Social Security #: ______ / ______ / ______

Tertiary Insurance: ______________________ Insured: ☐ Self ☐ Spouse ☐ Other

Subscriber: ________________ Date of Birth: ________ Policy or ID#: ____________________

Group#: ________________ Social Security #: ______ / ______ / ______

Local Pharmacy	Address or Cross Streets	Phone	Fax
Mail Order Pharmacy	Address	Phone	Fax

Authorization and Assignment of Benefits

The above information is true to the best of my knowledge. I allow Ameli | Dadourian Heart Center to view prescription history from external sources. I allow Ameli | Dadourian Heart Center to obtain my results/records from radiology facilities, laboratory facilities, hospital facilities and any other medical providers. I hereby assign to the undersigned physician all payments for medical services rendered and authorize payment directly to them. I will be responsible for all non-covered services. I also authorize the physician to furnish information to insurance carriers concerning my illness and treatment. A copy of this original shall be valid as the original.

______________________________ ______________________

Signature of Patient, Parent, Guardian Date

AMELI I DADOURIAN
HEART CENTER

AUTHORIZATION FOR RELEASE OF PERSONAL AND HEALTH INFORMATION

Sean Ameli, MD   Berge Dadourian, MD

In the event, we at Ameli I Dadourian Heart Center, may need to reach you, may we ... *(check all that apply)*

- ☐ Speak only to you directly.
- ☐ Leave a message with spouse or family member.
- ☐ Call you on your cell. The number is __________ - ___________ - ___________
- ☐ Call you at work. The number is __________ - ___________ - ___________

I, *(your/representative name)* ________________________________ *(date of birth)* _____/_____/_____ *(mm/dd/yr)*, give my Ameli I Dadourian Heart Center physician, staff or representatives, authorization to disclose my protected health information and/or records to the following individuals and/or entities:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical records.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health and record information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices, which I obtained from my doctor's office. The following include limitations I would like to place on the use of this information:

____

Unless, otherwise revoked, this authorization will expire on the following date, event, or condition:

____________________________________. If I fail to specify a date this authorization will expire on (1) year from the signature on this form.

____ ________________________________
Signature of Patient   Date

____ ________________________________
Signature of Guardian or Personal Representative   Date

____ ________________________________
Signature of Employee   Date

PATIENT & FINANCIAL AGREEMENT

_______ *(Initials)* Patients, or Responsible Party, are required to pay their co-pay and deductible at time of service.

_______ *(Initials)* I understand that services rendered to me by Ameli | Dadourian Heart Center are my financial responsibility and that the Provider will bill my insurance company, as a courtesy, and that it is my responsibility to know my coverage and eligibility benefits and to verify the physician's status (in-network, preferred, out-of-network, etc.).

_______ *(Initials)* I understand that I am, or my Responsible Party, is responsible for payment of my bill and there may be charges which my insurance may not cover, and which I, or Responsible Party, will have to pay. I authorize payment of medical benefits directly to Ameli | Dadourian Heart Center.

_______ *(Initials)* I understand that Ameli | Dadourian Heart Center is a participating physician in the Medicare program. I understand that Medicare patients are responsible for the annual deductible and the amount equal to 20% of the Medicare allowable. I also understand that I may be required to sign an Advance Beneficiary Notice of Non-coverage (ABN) and pay at the time of service

_______ *(Initials)* I understand that there will be a $50 charge for any checks returned for insufficient funds.

_______ *(Initials)* I understand in fairness to the other patients that a 24-hour notice is required for cancelling appointments and I may be charged a fee of $25.00 if not cancelled 24-hours in advance. I also understand that if I do not show for my appointments three times that I may be dismissed from the practice.

_______ *(Initials)* I understand that should my insurance company send payment to me, I will forward the payment to Ameli | Dadourian Heart Center within two business days. I agree that if I fail to send the payment in a timely way and the Provider is forced to proceed with the collections process; I, or Responsible Party, will be responsible for any cost and attorney fees incurred by Ameli Heart Center to retrieve their monies.

_______ *(Initials)* I understand it is my responsibility to provide accurate insurance information and to immediately report any changes in my insurance coverage.

_______ *(Initials)* I understand that it is my responsibility to contact my physician regarding any and all results after any testing is performed. I understand and acknowledge that I should request any prescription refills at the time of the office visit.

_______ *(Initials)* I understand it may take 24-48 hrs. to refill prescriptions and up to 72 hrs. for medical records to be completed.

_______ *(Initials)* I authorize the Provider to initiate a complaint to the appropriate department of insurance, the insurance commissioner, or department of managed care, for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

I have read and agree to all the provisions of the above financial and patient agreement.

____
Print Name of Patient

____ ______________________
Signature of Patient Date

____ ______________________
Signature of Guardian or Personal Representative Date

MEDICAL RECORDS REQUEST

I hereby authorize and request records to be released

From: ____

To: Ameli | Dadourian Heart Center
400 S. Rampart Blvd.
Ste. 240
Las Vegas, Nevada 89145
Office: 702.906.1100
Fax: 702.906.1101

Requesting Physician: Sean Ameli, MD
Berge Dadourian, MD

____
Print Name of Patient

Date of Birth *(mm/dd/year)* ________ / _______ / _______

Social Security Number __________ - __________ - __________

____ ______________________
Signature of Patient Date

AMELI | DADOURIAN
HEART CENTER

PATIENT MEDICAL HISTORY

Name: ______________________ Date of Birth: ______________ *(mm/dd/year)*

Do you have, or have you had, any of the following?

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disease
- ☐ Blood Disease
- ☐ Breast Cancer/Lumpectomy
- ☐ Breathing Problems
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer ____________
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chest Pains/Angina
- ☐ Cirrhosis
- ☐ Congestive Heart Failure
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Deep Vein Thrombosis
- ☐ Defibrillator
- ☐ Depression/Feeling Blue
- ☐ Diabetes Type I or II
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Epilepsy
- ☐ GERD/Acid Reflux
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis Type ________
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Impotence
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Melanoma
- ☐ Memory Problems
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Neurologic Disorder
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sexual Issues
- ☐ Sinus Trouble
- ☐ Skin Cancer (non-melanoma)
- ☐ Sleep problems/apnea
- ☐ Stroke
- ☐ Thyroid Disease ________
- ☐ Tumors/Growths/Cysts
- ☐ Urinary Tract Infections
- ☐ Vitamin Deficiency
- ☐ ______________
- ☐ ______________
- ☐ ______________

Women: Are You:

☐ Pregnant/ Trying to get pregnant ☐ Taking oral contraceptives ☐ Breastfeeding Last menstrual period ________

List any Injuries/Surgeries:	Description:	Date:
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

List Prescription and Over-the-Counter Medications:	List Vitamins/Minerals/Herbs:

400 S. Rampart Blvd., Ste. 240 Las Vegas, NV 89145 PH: 702.906.1100 FAX: 702.906.1101 www.AmeliHeartCenter.com

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HEART CENTER

SOCIAL INFORMATION

Marital Status: Single / Married / Divorced / Widow / Partner

Name of Spouse/Partner: ______________________________

Children:

Name ______________________________ (M / F) ________ Age ________

Name ______________________________ (M / F) ________ Age ________

Name ______________________________ (M / F) ________ Age ________

Your Occupation: *(or past, if retired)* ______________________________

Dietary Style: *(normal, diabetic, low fat, low salt, vegetarian, etc.)* ______________________________

Physical Activity: *(type, how long, times per week)* ______________________________

Tobacco Use: Yes / No / Stopped   Age started: ________   Age stopped: ________

Product Type: ____________________   Amt. per day: ____________________

Alcohol Use: Yes / No   If yes, Product Type: ______________________________

How often: ____________________   How much: ____________________

Caffeine Use: Yes / No   If yes, Product Type: ______________________________

How often: ____________________   How much: ____________________

High Stress Level: Yes / No   If yes, Reason: ______________________________

Pharmacy:

Name of Pharmacy: ____________________   Phone Number: ____________________

Address: *(if unknown, what are the cross streets)* ______________________________

Allergies:

Are you allergic to anything? Yes / No   If yes, What: ______________________________

Are you allergic to any of the following?

- ☐ Bee stings
- ☐ Eggs
- ☐ Milk
- ☐ Seafood/Shellfish
- ☐ Contrast Dye/Iodine
- ☐ Latex
- ☐ Peanuts
- ☐ Statins

AMELI I DADOURIAN
HEART CENTER

PATIENT FAMILY HISTORY

Name: ____ Date: ____________________

Family History: *Please list all significant illness, past and present.*

Biological Father:

Current age: __________ If deceased, age and cause of death: ______________________________

Medical Problems: ____

____

____

____

Biological Mother:

Current age: __________ If deceased, age and cause of death: ______________________________

Medical Problems: ____

____

____

____

Sibling: (M / F) __________ Age __________ Medical Problems: ______________________________

____

Sibling: (M / F) __________ Age __________ Medical Problems: ______________________________

____

Sibling: (M / F) __________ Age __________ Medical Problems: ______________________________

____

Sibling: (M / F) __________ Age __________ Medical Problems: ______________________________

____

Other medical problems that run in your family: *(condition and relatives affected)* ____________________

____

PT. Name: ____________________ D.O.B: ___________ Date: _______

Annual Screening	Month & Year Completed	Next one due?	Recommended tests for you
Bone Scan/Dexa Scan- Every two years			
Fecal/Stool Test- yearly			
Last Eye Exam- Yearly especially with Diabetes			
Podiatry/Foot Exam- Yearly, especially with Diabetes			
Dermatology Exam/Skin Screening- Yearly			
Mammogram-Yearly			
Pap Smear- as recommended			
PSA-Yearly			
Colonoscopy- As recommended- 1st one at age 45+ for screening			
Do you Smoke	Yes	No	Former Smoker
Last Chest CT?			
Do you know your blood Type?	Yes	No	Type-
Last Annual Exam with us?			
Immunizations:			
Flu Vaccine: Once a year			
Prevnar 13: One time- 50+			
Pneumovax: Every 10 Years			
Shingles/Varicella/ Herpes Zoster: one time			
Tdap: Every ten years			

Patient Name: ______________________ DOB: __________ Date: _________

List of all the Doctors:

Allergist	
Dentist	
Dermatologist	
Electrophysiologist	
Endocrinologist	
ENT	
Gastroenterologist	
Gynecologist	
Hematologist	
Nephrologist	
Neurologist	
Oncologist	
Ophthalmologist	
Pain Management	
Physiologist	
Podiatrist	
Psychiatrist	
Pulmonologist	
Rheumatologist	
Urologist	

DO YOU SEE ANY OTHER SPECIALISTS THAT ARE NOT LISTED?

Patient Name: ____________________DOB:_______________________ Date: _________

Please list here any questions, concerns, or points of discussion you wish to have with your physician.