HOSMANE CARDIOLOGY

working to improve your heart health

PATIENT DEMOGRAPHIC INFORMATION

(Please Print)

FULL NAME: _____ **SS#:** _____-_____-_____
STREET ADDRESS: _____**APT. #**_____
CITY: _____**STATE**: _____ **ZIP**: _____
DATE OF BIRTH: _____/_____/_____ **SEX:** (M / F)
Month Day Year
HOME PHONE#: (_____) _____-_____ **CELL PHONE#:** (_____) _____- _____
WORK PHONE #: (_____) _____-_____ ***May we contact you at work**? (Y / N)
PATIENT EMPLOYER: _____
ETHNICITY: _____ **HISPANIC** (Y / N)
EMAIL ADDRESS: _____ **PATIENT PORTAL:** (Y / N)

INSURANCE SUBSCRIBER INFORMATION:
NAME: _____ **DOB**: _____ **RELATION TO PT:** _____

Who may receive information regarding your Health Information, Lab Results, and Appointment information? (Other than Primary Care Physician**)**

_____

May we leave messages regarding test results/appointments on your answering machine? (Y / N)

I have been given the opportunity to receive a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

I authorize Hosmane Cardiology, LLC to release any medical information to my insurance company or third party payers for completion of insurance claims and determination of benefits. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Medicare program or its intermediates or carriers or to the professional standards review organization.

With this consent, Hosmane Cardiology may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out billing, collections, appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others, unless I put my wishes to not have this done in writing.

I assign payment directly to Hosmane Cardiology, LLC for all medical services provided to me, and allow them to bill my health insurance on my behalf for any and all services I receive.

Signature: _____ **Date:** _____

Circle One (PATIENT / LEGAL GUARDIAN / POWER OF ATTORNEY

Please continue to next page

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Cardiology History Questionnaire

Name _____ Date of Birth _____

Primary Care Doctor: _____ Pharmacy/Location: _____

Are you adopted, or have no knowledge of your parents' health history? (Y / N)

*****Please only check conditions that apply*****

Disease/Condition	*Self*	*Mother*	*Father*	*Brother*	Sister	*Grandparent (M/F)*
Abnormal EKG						
Atrial Fibrillation						
Irregular Heart Beat						
Arrhythmia						
Pacemaker						
Defibrillator						
Cardiomyopathy						
Enlarged Heart						
Congestive Heart Failure						
Sudden Cardiac Death (including age)						
Angina						
Coronary Artery Disease						
Cardiac Catheterization						
Coronary Bypass						
Stent Placement						
Heart attack (including age)						
Heart Murmur						
Heart Valve Disease						
Aneurysm (Aorta)						

Please continue to next page

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Disease/Condition	*Self*	*Mother*	*Father*	*Brother*	*Sister*	*Grandparent (M/F)*
High Blood Pressure						
High Cholesterol						
Sleep Apnea						
Stroke						
TIA						
Diabetes						
Kidney Disorder						
Liver Disorder						
Pulmonary Embolism						
Cancer						
Dementia						
COPD						
Emphysema						
Aneurysm (Brain)						

Any other diseases that run in your family not mentioned above? Yes [ ] No [ ]
If Yes, please list:_____

Have you had any of these symptoms in the past 2 weeks:

[ ] Chest Pain [ ] Shortness of Breath [ ] Difficulty Breathing

[ ] Jaw Pain [ ] Swelling of Extremities [ ] Left Sided Pain

Allergies to Medications:

_____

Please list your Current Medication Names, Milligrams and Dosage Instructions:

_____

_____

_____

_____

Please continue to next page

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Alcohol Usage: [ ] Current [ ] Past [ ] Never

How often? _____ Type Consumed?_____

Tobacco Usage: [ ] Current [ ] Past [ ] Never

Type used?_____ How much per day? _____ Years Used? _____

Electronic Vape Usage: [ ] Current [ ] Past [ ] Never

Substance Usage: [ ] Current [ ] Past [ ] Never

Types of Substances Used? _____ How long ago? _____

Employment: [ ] Employed [ ] Retired [ ] Unemployed

Type of work do you perform? _____

Marital Status [ ] Single [ ] Married [ ] Widowed

[ ] Divorced [ ] Life Partner [ ] Seperated

Exercise/Activity [ ] Never [ ] Occasional [ ] Daily

Please Describe what Kind: _____

_____

Please Note anything you would like the physician to be aware of:

_____

_____

_____

_____

_____

Please continue to next page

United Medical Accountable Care Organization
161 Becks Woods Drive
Bear, DE 19701

UMACO CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that you provide the office more than 24 hours' notice. This enables the availability of the appointment slots to other patients in need of care. **New** patients who cancel less than 24 hours' notice are subject to a cancellation fee of **$100** and will not be rescheduled until payment is made. **Established** patients who cancel less than 24 hours' notice are subject to a cancellation fee of **$75** for physician appointments, and all patients are subject to a cancellation fee of **$100** for imaging procedures.

Patients who do not show up for their appointment without notice to the office, will be considered a "**NO SHOW"** and are subject to the **fees listed above** (patients with Medicaid are excluded however the No Show will be documented with their insurance company). Patients who No show two or more times will receive a No Show Letter emphasizing the importance of keeping scheduled visits and the ramifications of failing to keep future appointments. Patients who continue to No Show after receiving the No Show initial letter, are subject to be discharged from the practice and will be denied any future appointments.

Both the Cancellation and No-Show fees are the patient's sole responsibility and must be **paid in full before** the next appointment. We understand that unavoidable circumstances may cause you to cancel less than 24 hours prior to your appointment; therefore, fees in these instances may be waived per our management discretion. Our practice firmly believes that good physician/ patient relationships are based upon understanding and clear communication.

Please sign below acknowledging that you have read, understand and agree to the Cancellation and No-Show terms above.

Patient Name (Please Print)	**Date of Birth**
Signature of Patient or Patient Representative	**Date**

Date _____ Hosmane Cardiology-Patient Sleep Questionnaire

Full Name _____

Date of Birth _____

Insurance_____ PCP: _____

Currently using CPAP: Y/N **Tested for Sleep Apnea within the last 12 months: Y/N**

If you have answered YES to either question above, please do not complete below.

WHY ARE WE ASKING ABOUT YOUR SLEEP?

SLEEP APNEA

- MAY INCREASE YOUR BLOOD PRESSURE
- MAY INCREASE YOUR RISK FOR ATRIAL FIBRILLATION
- MAY INCREASE YOUR RISK FOR STROKE
- MAY INCREASE THE RISK OF DIABETES AND OBESITY

PLEASE ANSWER THE QUESTIONS BELOW:

- DO YOU SNORE LOUDLY? YES / NO
- DO YOU OFTEN FEEL TIRED OR SLEEPY DURING DAYTIME? YES / NO
- HAVE YOU NOTICED OR BEEN TOLD THAT YOU STOP BREATHING OR CHOKE DURING SLEEP? YES / NO
- DO YOU HAVE OR ARE YOU CURRENTLY BEING TREATED FOR HIGH BLOOD PRESSURE? YES / NO
- ARE YOU MALE? YES / NO
- ARE YOU OVER 50 YEARS OLD? YES / NO
- HEIGHT _____
- WEIGHT _____

WE WILL TAKE IT FROM HERE!

----------Office Use Only. Please do not write below this line--------

BMI > 35 Kg/m2? YES / NO

HOW MANY QUESTIONS ABOVE ARE ANSWERED "YES"? ----------

*YES TO 3 OR MORE = AT RISK FOR SLEEP APNEA

Order WatchPAT: YES/NO

PLEASE CONTINUE TO NEXT PAGE