**Meg Sullivan MD**
Cardiology

802 W Lampasas St • Ennis, TX 75119
Tel 972-875-4700 • Fax 972-878-2238

# NEW PATIENT INFORMATION

LAST NAME FIRST MIDDLE

DATE OF BIRTH SSN

Address: Number and street

City State Zip

HOME PHONE MOBILE WORK

Do we have your permission to leave a detailed message on your voicemail? Yes or No If yes, which number? _____

Emergency contact name Phone

Please sign below to consent to treatment:

I consent to treatment necessary for the care of the patient indicated above. Authorization is hereby granted to release information as may be necessary to process and complete any insurance claim.

Signature of patient Date

**Meg Sullivan MD PA** **NEW PATIENT INFORMATION**

***Welcome!*** Please provide us with the information below to the best of your ability.

**Name:** _____ **Date of birth:** _____

1. **Please check the following diagnoses as they apply to you:**
   - ☐ High blood pressure
   - ☐ Coronary artery disease
   - ☐ Heart attack
   - ☐ Heart artery blockages
   - ☐ Chest pain
   - ☐ Congestive heart failure "CHF"
   - ☐ Heart murmur
   - ☐ Heart rhythm problems
   - ☐ Racing heart
   - ☐ Stroke
   - ☐ Diabetes
   - ☐ Gout
   - ☐ Leg artery disease
   - ☐ Peripheral vascular disease

2. **Please check the following symptoms if you have recently experienced a change in these symptoms:**
   - ☐ Shortness of breath
   - ☐ Chest pain
   - ☐ Racing heart
   - ☐ Skipped beats
   - ☐ Passing out
   - ☐ Dizzy spells
   - ☐ Strong heart beats
   - ☐ Swelling in your legs

3. **Have you been hospitalized in the past year for chest pain or shortness of breath?**
   ☐ Yes ☐ No
   If so, what hospital(s)? Please list only those in the last year.
   _____

4. **Have you had an ultrasound of your heart before?** ☐ Yes ☐ No
   **If yes, when was the last one?** _____ (don't worry about specific dates)

5. **Have you had a stress test before?** ☐ Yes ☐ No
   **If yes, when was the last one?** _____ (don't worry about specific dates)

6. **Have you had a cardiac catheterization before?** (This is when you have a procedure through the leg that looks at the heart arteries directly, done in a special procedure suite)

   ☐ Yes ☐ No

If yes, please list the year and where to the best of your recollection:

_____

7. **Do you have stents in the heart arteries?** ☐ Yes ☐ No
   If yes, how many? _____
   When was the last one? _____

8. **Do you smoke?** ☐ Yes ☐ No
   **Did you used to smoke?** ☐ Yes ☐ No
   Total number of years you have smoked, even if you have quit: _____
   Number of packs per day that you smoke or used to smoke: _____

9. **Do any of the following family members have a history of heart attack, bypass surgery or stents?**
   Mother ☐ Yes ☐ No _____
   Father ☐ Yes ☐ No _____
   Brothers or sisters ☐ Yes ☐ No _____

10. **Have you seen a cardiologist before?** ☐ Yes ☐ No

11. **Who is your primary care doctor to whom we should send a copy of our consultation?**

_____

**REMINDER!**

Please bring a **CURRENT MEDICATION LIST or your MEDICINE BOTTLES** to every appointment. This not only helps us prevent medication errors, it is also a good idea to always have a list of your medications with you in case you are ever in an emergency situation.

**Thank you!**

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# GENERAL PRACTICE POLICIES

Please be ready to provide the following at each visit to the reception

- Insurance cards
- Picture identification
- Any updates to your information since your previous visit

Please bring an updated medication list or your medicine bottles to each visit. If you need help generating a list, we can help you with that. This helps us to better treat you and to save time for you and for us!

REGARDING RETURN TELEPHONE CALLS:
During clinic hours, there is always someone at the desk taking calls. If that person is on the phone with another patient, or helping someone get checked in or out, then your call will go to voicemail. We make every attempt to call patients back by the end of the business day, usually sooner. Please leave a message so that we can get back to you. If your call is not returned by 4:30 of the same day, please feel free to call us back.

_____ _____
Patient signature Date

_____
Patient name

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## ACKNOWLEDGEMENT OF REVIEW OF "NOTICE OF PRIVACY PRACTICES"

I have reviewed Ennis Doctors Center's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to see a copy of this document.

_____
Signature of patient or patient's representative

_____
Date

_____
Name of patient or representative

_____
Description of personal representative's authority, if applicable

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# POLICY REGARDING PAYMENTS

Our office requires payment of copays prior to the visit and any remaining portion of deductibles, balances, copays and/or co-insurance at the end of your visit today.

We attempt to provide an estimate of charges prior to your visit. This estimate does not include additional services such as lab, injections or x-rays. Please be aware of the insurance plan's provisions regarding referrals, outpatient procedures and non-covered services.

If proper insurance documentation is not provided at your visit, no refunds or adjustment amounts will be made at a later date.

Payment on any balance not paid by your insurance after adjustments is expected within 30 days of notification by means of a statement, letter or other means of communication. If insurance does not pay for the visit within a reasonable amount of time, the balance is the patient's responsibility.

We have a qualified, experienced staff that can assist you with many of your insurance problems, but because of the volume of different insurance plans we are unable to be familiar with every aspect of each plan. It is our goal to provide you with the best medical care while being sensitive to the provisions of your insurance policy.

Thank you!

I, _____, have read and understand the
printed patient name

payment policies above and that I am responsible for paying my balance of charges at the end of the visit today.

_____ _____
Patient signature Date

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# CARDIAC TESTING POLICY

This policy applies to the following procedures:

- CARDIAC ULTRASOUND (ECHOCARDIOGRAM)
- STRESS ECHOCARDIOGRAM
- TREADMILL STRESS TESTING
- RHYTHM MONITORS

I understand that if I am scheduled for any cardiac testing and fail to notify the office of cancellation **24 hours prior** to my test, I will be charged a **$50.00 fee.**

_____ _____

Patient signature Date

_____

Printed name

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## NO-SHOW AND CANCELLED APPOINTMENTS POLICY

This policy applies to all appointments for initial consultations and for follow-up visits.

- When you do not show for a scheduled appointment, we are not able to offer that appointment to another patient who is waiting to be seen.

- If you have three no-shows, we will not reschedule you for any further appointments.

I understand that if I am scheduled for an appointment with Dr. Meg Sullivan and fail to notify the office of cancellation **24 hours prior** to my appointment, I will be charged a **$30.00 fee.**

I also understand that if I do not show for three appointments, I will not be rescheduled to be seen in this practice.

_____ _____

Patient signature Date

_____

Printed name