



3601 W. 13 Mile Road Royal Oak, Michigan 48073 248.898.4163 fax 248.898.5596

PATIENT HISTORY FORM

Name: (Last) _____ (First) _____ (MI) _____

Date of birth: _____ Age: _____ Sex: F _____ M _____ Today's Date: _____

Address: (Street) _____ Apt/Lot#: _____

City, State: _____ Zip Code: _____

Phone: () _____ Alternate phone: () _____

Driver's license: _____ Social Security #: _____

Employer: _____ Work Phone: _____

(Address) _____

Spouse name: _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Work Phone: _____

(Address) _____

Emergency contact:(Name, relationship, phone): _____

Email address: _____ (for our communication purposes only)

PRIMARY INSURANCE INFORMATION

Insurance Co: _____ Contract #: _____ Group #: _____

Plan #: _____ Insurance address: _____

Insured's name: _____ Relationship: _____ Self Spouse Dependent

Insured's address: _____ City, State: _____ Zip Code: _____

Insured's employer: _____ Insured's social security # _____

Insured's date of birth: _____ Sex: F _____ M _____

SECONDARY INSURANCE INFORMATION

Insurance Co: _____ Contract #: _____ Group #: _____

Plan #: _____ Insurance address: _____

Insured's name: _____ Relationship: _____ Self Spouse Dependent

Insured's address: _____ City, State: _____ Zip Code: _____

Insured's employer: _____ Insured's social security # _____

Insured's date of birth: _____ Sex: F _____ M _____

HEALTH ASSESSMENT

Name: _____ Allergies: _____

Age: _____ Ht: _____ Wt: _____

Current Problem (reason for seeing Cardiologist) _____

CURRENT PHYSICIANS

INTERNIST/FAMILY PHYSICIAN	CARDIOLOGIST
(name) _____	(name) _____
(address) _____	(address) _____
(phone) _____ (fax) _____	(phone) _____ (fax) _____
<input type="checkbox"/> Send records to above	<input type="checkbox"/> Send records to above

Who referred you to our practice? _____

if not listed above: Address _____ Phone: _____

Fax _____

Social History

Past Medical History

Occupation: _____	Surgeries: _____
Retired: Y N	
Marital Status: M S D W	
Alcohol use: Daily? Amount: _____	Have you had a heart cath? Y N Date(s): _____
	Have you had a stress test? Y N Date(s): _____
Smoker: Y N Amount: Years: _____	Have you had a heart attack? Y N Date(s): _____
	PTCA/Angioplasty? Y N Date(s): _____
	Stent placement? Y N Date(s): _____

Current Medications

Family History

Name	Dose	Frequency	Has anyone in your immediate family had:			
			Heart attack?	Y N	Who?	Age?
			Heart Cath?	Y N	Who?	Age?
			PTCA/Angio?	Y N	Who?	Age?
			Stent placement?	Y N	Who?	Age?
			Stroke?	Y N	Who?	Age?
			Diabetes?	Y N	Who?	Age?
			Cancer?	Y N	Who?	Age?

Preferred pharmacy: _____ Phone: _____

Address: _____ Fax: _____

I understand that, as a courtesy, Academic Heart & Vascular PLLC (AHV) will bill my insurance carrier. I authorize benefits be paid directly to AHV and the release of any medical information needed to determine these benefits. I understand that I am responsible for all deductibles, copays and other amounts not covered by my insurance carrier and if known, these amounts are expected at the time of service.

I certify that the above information is correct.

Patient Signature: _____ Date: _____