CARDIOVASCULAR INSTITUTE OF MICHIGAN, PC
DEMOGRAPHIC AND GENERAL REQUIRED INFORMATION

THANK YOU FOR COMPLETING ALL AREAS OF THIS INFORMATION PAGE

We request only information that is required for billing purposes and what is required for your medical record.

PATIENT NAME: _____ SOCIAL SECURITY#____-____-____

MALE _____ FEMALE_____ DATE OF BIRTH _____-_____-_____ ALIASES (if applicable)_____

PERMANENT ADDRESS:_____
STREET CITY STATE ZIP

TEMPORARY / CONFIDENTIAL ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE: _____ WORK:_____ CELL:_____

May we leave a message on your answering machine/voicemail regarding test results, medical instructions and/or appointments?

_____YES _____NO ANY SPECIAL INSTRUCTIONS: _____

EMAIL ADDRESS: _____

MARITAL STATUS: **CIRCLE ONE**: Married Single Widowed Divorced Separated

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE:_____

WHO MAY WE RELEASE YOUR MEDICAL INFORMATION TO?

NAME _____ RELATIONSHIP_____ PH# _____

NAME _____ RELATIONSHIP_____ PH#_____

LOCAL PHARMACY _____ LOCATED AT _____ PH#_____

MAIL ORDER PHARMACY _____ LOCATED AT _____ PH#_____

LANGUAGE SPOKEN: _____ ENGLISH or OTHER _____

RACE: ***CIRCLE ONE:*** American Indian Asian Black or African American American European Greek Hispanic Italian Middle Eastern White Other _____ NATIONALITY: _____ (COUNTRY OF ORIGIN)

PRIMARY CARE DOCTOR: _____ PHONE: _____

WHO REFERRED YOU TO OUR PRACTICE? _____

DO YOU HAVE AN ADVANCED DIRECTIVE? _____YES ____NO DO YOU HAVE A DURABLE POWER OF ATTORNEY _____YES _____NO

IF YES, NAME OF PERSON: _____ PHONE: _____

NAME OF PRIMARY INSURANCE: _____ SECONDARY INSUR: _____

EMPLOYMENT STATUS: _____ FULL TIME _____PART TIME _____ NOT EMPLOYED _____ SELF _____ RETIRED _____DISABILITY

POLICY HOLDER NAME: _____ DOB: _____ RELATIONSHIP: _____

_____ _____
PATIENT SIGNATURE DATE

Do not complete unless instructed.

I have reviewed and attest that the above information is correct (initial) _____ Date _____

PATIENT HISTORY

Patient Name: _____

PAST SURGICAL HISTORY:

Date	Surgery	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PACEMAKER / ICD Date / Year of Implant: _____Manufacturer of Device: _____

Cardiac Catheterization: Date: _____ Hospital: _____

STENT Placement: Yes / No (drug eluting or bare metal)

STENT Location: _____

Why are you seeing the Doctor today?

Circle all that apply:

Chest Pain Chills Coughing Blood Belching Blurred Vision Bruise Easily Decreased Appetite

Dizziness Double Vision Fatigue (tired) Fever Headaches Hiccups Hypertension (High Blood Pressure)

Known Heart Condition Irregular Heart Beats Insomnia (trouble sleeping) Palpitations Persistent Cough

Nausea / Vomiting Night Sweats Shortness of Breath Swelling of Extremities Syncope (passing out)

Weight (Gain or Loss)

Concerns not covered in the Medical History Form:

_____

_____

_____

_____

_____

PATIENT HISTORY

Patient Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____ Handed (circle one) Right / Left

List All Allergies: _____

Are you allergic to Iodine? Yes / No

Social History:

Caffeine (circle one) Yes / No Cups per day _____

Smoking (circle one) Currently Former Never # Packs per day: _____ How Long: _____ Years Quit: _____

Alcohol (circle one) Social Occasional Never # Drinks per week: _____

Illegal Substance Use: Please list _____

PAST MEDICAL HISTORY (circle all that apply)

Ablation Asthma Anemia Aneurysm Angina (Chest Pain) Arrhythmia Atrial Fibrillation

Bleeding Disorder Cancer (type):_____ Cardiomyopathy Coronary Artery Disease Stroke

Diabetes I or II (medication / insulin / both) DVT (blood clot) Emphysema Heart Murmur

High Cholesterol Hypertension (high blood pressure) Hypotension (low blood pressure)

Hyperthyroid Hypothyroid Myocardial Infarction (heart attack) TIA Pulmonary Embolism

Pericarditis Renal Failure Syncope (fainting, passed out) Valve Disease

MALE: History of Urinary Retention Prostate Problems Erectile Dysfunction

FEMALE: Menopause (circle one) Yes / No Date of last menstrual period: _____

Birth Control (circle one) Yes / No Name of Rx: _____Type:_____

FAMILY HISTORY:

Mother: (circle one) Living Deceased Age at Death: _____
Her Medical History: _____

Father: (circle one) Living Deceased Age at Death: _____
His Medical History: _____

Siblings/ Health History: _____

Cardiovascular Institute of Michigan, PC

PLEASE REVIEW SECTIONS 1-3 AND SIGN AT BOTTOM OF FORM

SECTION 1

ASSIGNMENT AND AUTHORIZATION OF BENEFITS

I acknowledge that patients who do not have insurance coverage are expected to pay at the time services are rendered. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance and all other plans to Cardiovascular Institute of Michigan, PC. I understand that I am financially responsible for all charges co-payments, co-insurance and deductibles. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payers and or other health care providers. I authorized disclosure of any medical information necessary to process related claims. By signing below, I authorize insurance claims be filed and benefits assigned. I request that payment of authorized benefits be made on my behalf to Cardiovascular Institute of Michigan for any services rendered to me. I will be responsible for any electronic copy of my medical records once they are released to me.

SECTION 2

ACKNOWLEDGEMENT OF RECEIPT AND REVIEW OF NOTICE OF PRIVACY PRACTICES – HIPAA/SECURITY POLICY

If you feel that we may have violated your privacy rights, please contact Cardiovascular Institute of Michigan. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to contact us directly or the US DHHS to file a complaint.

I acknowledge that I have received the Notice of Privacy Practices- HIPAA/Security Policy

SECTION 3

Thank you for choosing Cardiovascular Institute of Michigan. We look forward to working closely with you.

As part of our Patient Centered Medical Home Team (PCMH), I acknowledge that I have reviewed the Patient–Provider Partnership Specialist Agreement and that I share in the responsibility for my own health and will work closely with my physician and treatment recommendations for my health care.

I am aware that if I am experiencing a medical emergency at any time, I need to call 911 or go to the nearest Emergency Room.

☐ I acknowledge that I have read and understand Sections 1,2,3 as stated above.

_____ _____

Signature of Patient/Parent/Patient Representative Date

CARDIOVASCULAR INSTITUTE OF MICHIGAN, PC

Dr. Ajjour ▪ Dr. Barbish ▪ Dr. Sbahi ▪ Dr. Alzagoum ▪ Dr. John-Rosman ▪ Dr. Shakir

18303 E. TEN MILE ROAD, SUITE 100
ROSEVILLE, MI 48066
PH: 586-776-8877 / FAX: 586-776-3092

43230 GARFIELD ROAD, SUITE 150
CLINTON TOWNSHIP, MI 48038
PH: 586-412-7251 / FAX: 586-412-7281

AUTHORIZATION TO **RELEASE MEDICAL INFORMATION TO** CARDIOVASCULAR INSTITUTE OF MICHIGAN, PC

Patient Name _____ Date of Birth _____

Address _____City _____State _____ Zip _____

Social Security Number (last four digits) _____

I AUTHORIZE _____
NAME YOU ARE **REQUESTING RECORDS FROM** PHONE NUMBER

TO RELEASE THE REQUESTED INFORMATION CONTAINED IN MY MEDICAL RECORD (INCLUDING IF APPLICABLE, INFORMATION ABOUT HIV OR AIDS, SUBSTANCE ABUSE TREATMENT AND INFORMATION ABOUT MENTAL HEALTH SERVICES)

RELEASE RECORDS TO: CARDIOVASCULAR INSTITUTE OF MICHIGAN, PC

PLEASE CHECK THE CARDIOVASCULAR INSTITUTE OF MICHIGAN, PC LOCATION YOU WANT YOUR RECORDS SENT TO

_____ 18303 TEN MILE ROAD ▪ SUITE 100 ▪ ROSEVILLE ▪ MI ▪ 48066 PH: 586-776-8877 FAX: 586-776-3092

_____ 43230 GARFIELD ROAD, SUITE 150 CLINTON TOWNSHIP, MI 48038 PH: 586-412-7251 FAX: 586-412-7281

TYPE OF RECORDS REQUESTED: _____ RADIOLOGY REPORTS/FILM _____ LAB RESULTS
_____OPERATIVE REPORTS _____ PATHOLOGY REPORTS _____ OFFICE NOTES _____ HOSPITAL NOTES

OTHER (SPECIFY) _____

PURPOSE OR NEED FOR SUCH DISCLOSURE: _____

TREATMENT DATES FROM: _____TO _____.

For mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, II must do so in writing and present my written revocation to the Health Information Management Department. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law.

Your protected health information will be disclosed as specified in this authorization. This authorization will expire 1 year from the date of signature, or until we have completed the disclosure(s) you have requested, whichever is shorter. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

_____ _____
Signature of Patient/Parent/Personal Representative Date

_____
Relationship to Patient

CARDIOVASCULAR INSTITUTE OF MICHIGAN, PC

Dr. Ajjour ▪ Dr. Barbish ▪ Dr. Sbahi ▪ Dr. Alzagoum ▪ Dr. John-Rosman ▪ Dr. Shakir

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PH: 586-412-7251 / FAX 586-412-7281

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO OTHER

Patient Name: _____ Date of Birth: _____

Address_____ CITY _____STATE_____ZIP_____

Social Security Number (last four digits) _____

I AUTHORIZE: CARDIOVASCULAR INSTITUTE OF MI, PC

18303 TEN MILE ROAD, SUITE 100
ROSEVILLE, MI 48066
PH: 586-776-8877 Fax: 586-776-3092

OR

43230 GARFIELD ROAD, SUITE 150
CLINTON TOWNSHIP, MI 48038
PH: 586-412-7251 FAX: 586-412-7281

TO RELEASE REQUESTED INFORMATION CONTAINED IN MY MEDICAL RECORD (INCLUDING IF APPLICABLE, INFORMATION ABOUT HIV OR AIDS, SUBSTANCE ABUSE TREATMENT AND INFROMATION ABOUT MENTAL HEALTH SERVICES).

PURPOSE OR NEED FOR SUCH DISCLOSURE: _____

For mental health records, or records pertaining to HIV infection or AIDS, the above paragraph must include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure.

REQUESTED RECORDS: _____

OTHER (SPECIFY) _____

TREATMENT DATES FROM: _____TO: _____

RECORDS TO BE RELEASED TO: _____

_____

_____

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 Health Information Management Department. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation of authorization unless otherwise allowed by law.

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_____ _____

Signature of Patient/Parent/Personal Representative Date

_____ _____

Relationship to Patient Date