

ORANGE CARDIOLOGY, P.L.L.C.

INSURANCE INFORMATION FORM

PATIENT NAME (LAST, FIRST, M.I.)			SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF VISIT
PATIENT ADDRESS (STREET, CITY, STATE, ZIP)				
DATE OF BIRTH	SOCIAL SECURITY NO.	HOME PHONE NO. ()		MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
EMPLOYER NAME			EMPLOYER TELEPHONE NO. ()	
EMPLOYER ADDRESS (STREET, CITY, STATE, ZIP)				
SPOUSE'S NAME		SPOUSE'S EMPLOYER NAME		SPOUSE'S EMPLOYER TELEPHONE NO. ()
SPOUSE'S EMPLOYER ADDRESS (STREET, CITY, STATE, ZIP)				
IF FULL-TIME STUDENT INDICATE SCHOOL CURRENTLY ATTENDING			IF A MINOR, NAME OF PARENT OR GUARDIAN	
EMERGENCY NAME		RELATIONSHIP TO PATIENT	EMERGENCY TELEPHONE NO. ()	
REFERRING PHYSICIAN/FRIEND			HAVE YOU EVER BEEN SEEN BY ANY OF OUR DOCTORS PREVIOUSLY, IN THE HOSPITAL OR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

PRIMARY INSURANCE

NAME OF CARRIER		POLICY NO.	GROUP NO.
CARRIER ADDRESS (STREET, CITY, STATE, ZIP)			
CARRIER TELEPHONE NO. ()	POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT)		PATIENT RELATIONSHIP TO INSURED
SOCIAL SECURITY NO. OF POLICY HOLDER (IF DIFFERENT FROM PATIENT)		DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT)	

SECONDARY INSURANCE

NAME OF CARRIER		POLICY NO.	GROUP NO.
CARRIER ADDRESS (STREET, CITY, STATE, ZIP)			
CARRIER TELEPHONE NO. ()	POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT)		PATIENT RELATIONSHIP TO INSURED
SOCIAL SECURITY NO. OF POLICY HOLDER (IF DIFFERENT FROM PATIENT)		DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT)	

TERTIARY INSURANCE

NAME OF CARRIER		POLICY NO.	GROUP NO.
CARRIER ADDRESS (STREET, CITY, STATE, ZIP)			
CARRIER TELEPHONE NO. ()	POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT)		PATIENT RELATIONSHIP TO INSURED
SOCIAL SECURITY NO. OF POLICY HOLDER (IF DIFFERENT FROM PATIENT)		DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT)	

ASSIGNMENT OF BENEFITS: I authorize payment of Medical Benefits directly to Orange Cardiology P.L.L.C. for the services described. I understand that I am responsible to pay for services including reasonable attorney fees and costs of collection in the event of default.

Patient's Signature: _____ **Date:** _____

I authorize any holder of medical or any other information about me to release to the Social Security Administration and Health Care Financing Administrations or its intermediaries or carriers, or to the billing agent of this physician, any information used in place of the original, and request payment of Medical Insurance Benefits either to myself or to the party who accepts assignment.

Patient's Signature: _____ **Date:** _____

PLEASE COMPLETE REVERSE SIDE OF THIS FORM IF YOU WERE INJURED IN A CAR ACCIDENT OR ON THE JOB



Tel (845) 294-7700
Fax (845) 294-5363

ORANGE CARDIOLOGY, PLLC
PATIENT QUESTIONNAIRE

NAME: _____ DOB: ____/____/____ DATE: ____/____/____

Who referred you to our office, and why?
List current medications, including over-the-counter preparations, you have taken recently.
Please indicate how many mg per dose and how many doses per day.
Drug allergies? Any medical conditions/illness? Any surgeries, hospitalizations? Any recent x-rays or other tests?
Do you have a history of these conditions (Please check)
Hypertension, Diabetes, High Cholesterol, Heart Attack, Congestive Heart Failure, Peripheral Vascular Disease, Stroke or Mini-Stroke, Coronary Artery Disease
Pharmacy name and phone number
Do you smoke? Did you ever smoke? Do you drink alcohol? Do you use recreational drugs?
Does anyone in your family have any of the following?
Heart Disease, High Blood Pressure, Diabetes, Cancer, What organ, Arthritis, Bleeding Disorder, Kidney Disease, Thyroid Disease, Brain Tumors, Aneurysm, Stroke, Dementia, Muscle Disorder, Sensory Disorder, Incoordination, Shaking, Seizures, Headaches, Mental Illness, Attention Deficit /Hyperactivity
Do you exercise? Date of last menses: Could you be pregnant? Height Weight
Age of Mother & Father (if deceased, state cause)
Comments

Have you recently experienced any of the following? (Please use the bottom of this page to elaborate when pertinent)

Yes No Yes No Yes No Yes No Yes No
Fever, Weight Loss/Gain, Change in Appetite, Visual Change, Hearing Loss, Earache, Ringing in Ears, Cough, Sore Throat, Change in Smell, Difficulty Swallowing, Nausea or Vomiting, Chest Pain, Palpitations, Shortness of Breath, Allergies, Constipation, Diarrhea, Abdominal Pain, Black or Tarry Stools, Blood in Stools, Problems Urinating, Sexual Problems, Joint Pain, Bone Problems, Neck/Low Back Pain, Shooting Pain/Sciatica, Muscle Pain, Skin Problem, Bleeding or Bruising, Anemia, Fatigue, Sleepiness/Sedation, Difficulty Sleeping, Anxiety, Depression, Headaches, Change in Mental Acuity, Memory Problems, Hallucinations, Agitation/Confusion, Personality Changes, Difficulty Speaking, Change in Taste, Dizziness/Vertigo, Clumsiness, Unsteadiness, Weakness, Numbness/Tingling, Stiffness/Slowness, Shaking, Other

REVIEWED BY: _____ DATE: _____

ORANGE CARDIOLOGY, P.L.L.C.
70 HATFIELD LANE
SUITE 203
GOSHEN, NEW YORK 10924

Viral Ras Sheth, M.D., F.A.C.C.

Themistoklis Nissirios, M.D.
Lisa A. Thayer, ANP-C

Practice Limited to
Cardiovascular Disease

PHONE: (845) 294-7700
FAX: (845) 294-5363

YOUR INSURANCE COMPANY

In the past few years the number of different health insurance programs has increased at an amazing rate. Even under one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know, or keep up to date with each program's provisions.

- Some programs require that a specific facility be used for your x-rays, ultrasounds or blood tests
- Some programs require pre-authorization, while other do not
- Some insurance companies require **PATIENTS** to notify them of hospital admissions or trips to the emergency room
- Some programs require specific information regarding hospitalizations

IT'S YOUR RESPONSIBILITY TO KNOW:

1. Whether this office is participating with your particular plan and program.
2. To advise this office of your program's requirements in advance each and every time we provide a service. We will do our best to comply with any reasonable requirements that your program may have.

Please understand that if we have not been advised in advance of your program's requirements or conditions and provide a service or use a laboratory that is outside of the program, you will be responsible for the appropriate fees. In addition, there are times that we may not be able to obtain a consultant or laboratory that is participating with our program. It will be up to you to work with your insurance company.

These are not our regulations, they are your insurance company's regulations, and unless you follow them carefully the insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a phone number for you to use if you have any questions about your coverage.

Knowledge receipt of this information

Signature

Date

HIPPA
ACKNOWLEDGMENT

I, _____, acknowledge that I have
been provided with a copy of ORANGE CARDIOLOGY PLLC's Privacy
Notice, and have been given an opportunity to read and ask questions about
the notice.

Date: _____

Patient Signature

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PHARMACY/MEDICATION HISTORY:

I authorize Orange Cardiology PLLC to obtain all of my medication history, as is medically necessary, in any format, to provide my medical care.

Print Name _____

Signature _____ Date _____

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We would like to keep you informed about current cardiology trends and office updates. Please fill out your e-mail address below and give to office staff.

NAME: _____

E-MAIL ADDRESS: _____