DESERT CARDIOLOGY AND VASCULAR CENTER

PATIENT REGISTRATION

DR. CHANDRA NARALA, MD, FACC., MBA
DR. KARTHIEK A. NARALA, MD, FACC, FSCAI
ARA MAY R. DELA TORRE, APRN, NP-C

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME_____ SUFFIX____

DOB: ____ / ____ / _____ AGE: _____ SSN: _____-____-_____ SEX: ____ M ____F

MARITAL STATUS: _____ HOME#_____ CELL # _____

ADDRESS: _____ _____APT#_____

CITY: _____ STATE: _____ _____ZIP: _____

E-mail Address _____

RACE: ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER **ETHNICITY:** ☐ HISPANIC OR LATINO
☐ ASIAN ☐ WHITE ☐ NOT HISPANIC OR LATINO

☐ BLACK OR AFRICAN AMERICAN ☐ DECLINED **LANGUAGE:** _____

EMPLOYER: _____ PH# _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY CARE PHYSICIAN:_____PH#_____

REFERRED BY: _____ REASON FOR REFERRAL: _____

***** IT IS OFFICE POLICY TO UPDATE PAPERWORK YEARLY*****

(NEXT YEARS PAPERWORK WILL BE SHORTER)

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY#: _____ GROUP#: _____

INSURED/GUARANTOR'S NAME: _____ DOB: ___/___/_____ SS#: _____/____/_____

EMPLOYER: _____ PH# _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SECONDARY INSURANCE: _____ POLICY#: _____ GROUP#: _____

INSURED/GUARANTOR'S NAME: _____ DOB: ___/___/_____ SS#: _____/____/_____

EMPLOYER: _____ PH# _____

THIRD INSURANCE: _____ POLICY#: _____ GROUP#: _____

INSURED/GUARANTOR'S NAME: _____ DOB: ___/___/_____ SS#: _____/____/_____

EMPLOYER: _____ PH# _____

EMERGENCY CONTACT INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

RELATIONSIP: _____ PH#: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

RELATIONSIP: _____ PH#: _____

POLICY ON DEDUCTIBLES

Deductibles that have not been satisfied for the year are going to be collected for New and Established patients on the day of service. Copays will be collected once deductible has been satisfied.
Deductibles for patients with double coverage will **NOT** be collected.

NEW PATIENTS: $175

ESTABLISHED PATIENTS: $75

******Deductibles for any testing the Doctor will order will also apply to the deductible. It will be collected on the day of the test, amount varies.**

******CO-INS for any office visits and testing the Doctor will order will also apply to the co-ins. It will be collected on the day of the test/office visit, amount varies.**

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ DATE: ___/___/_____

PLEASE READ AND SIGN BELOW

The above information is complete and correct. *AUTHORIZATION AND ASSIGNMENT OF BENEFITS:* I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the physician or group indicated on the claim. I understand that I am responsible for my deductible, copayments or amounts for services not covered by my insurance plan. All professional services rendered are charged to the patient, or guarantor, if minor. In the event of collection proceedings due to lack of payment, there may be additional charges for any and all collection fees. A copy of the signature is as valid as the original.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ DATE: ___/___/_____

PATIENT'S NAME: _____ DOB: _____

MEDICAL INFORMATION

ALLERGIES *List all medication or food allergies, as well as your reaction*

PREFERRED PHARMACY: _____ _____ **PH# _____**

CROSS STREETS AND ZIP CODE : _____

CURRENT MEDICATIONS *List ALL current medications including over the counter medications/vitamins/herbal/supplements*		
Medication Name	**Dosage**	**# Times Daily**

MEDICAL PROBLEMS			
CONDITION	**YEAR**	**CONDITION**	**YEAR**
☐ Angina		☐ Thyroid Disease ☐ Hyper? ☐ Hypo?	
☐ Coronary Artery Disease		☐ Liver Disease	
☐ Heart Attack		☐ Kidney Disease	
☐ Heart Failure (CHF)		☐ Arthritis	
☐ Heart Valve Disease		☐ Migraine Headaches	
Type:		☐ Seizures	
☐ High Blood Pressure		☐ Stroke	
☐ High Cholesterol		☐ Anemia	
☐ Irregular Heart Rhythm		☐ Bleeding/Clotting Disorder	
Type:		☐ Cancer	
☐ Peripheral Vascular Disease		Type:	
☐ Asthma		☐ GERD	
☐ Lung Disease (COPD)		☐ Depression	
☐ Tuberculosis		☐ Emotional/Behavioral Illness	
☐ Colitis		Explain:	
☐ Stomach Ulcer		☐ AIDS/HIV	
☐ Gout		☐ Other	
☐ Diabetes ☐ Type I? ☐ Type II?		Explain:	

PATIENT'S NAME: _____ **DOB:** _____

MEDICAL INFORMATION

PREVIOUS SURGERIES	
SURGERY	**YEAR**

FAMILY MEDICAL HISTORY *Does anyone in your immediate family have the following? Who?*			
CONDITION	**WHO?**	**CONDITION**	**WHO?**
☐ Coronary Artery Disease		☐ Cancer (type): _____	
☐ Heart Attack		☐ Diabetes	
☐ Sudden Cardiac Death		☐ COPD	
☐ High Blood Pressure		☐ Stroke	
☐ High Cholesterol		☐ Aneurysm: _____	
☐ CHF/Heart Failure		☐ Other	
Father's Cause Of Death? _____	Age:	Mother's Cause Of Death? _____	Age:

SOCIAL HISTORY	
Caffeine (coffee, tea, soda…)? ☐ Yes ☐ No	How many servings per day?

TOBACCO USE *(Cigarettes, cigars, pipes and smokeless tobacco)*	
☐ Current every day smoker	Pack/s per day? ___ Smoking for how many years? ____
☐ Former Smoker	Quit, what year? ___ Smoked for how many years? __
☐ Never Smoker	
☐ Current someday smoker	
☐ Smoker, current status unknown	
☐ Unknown if ever smoked	
☐ Heavy tobacco smoker	
☐ Light tobacco smoker	

ALCOHOL USE					
How often do you drink?	☐ Never	☐ Occasionally	☐ Socially	☐ Daily	☐ Weekly
Number of drinks _____	☐ Beer	☐ Red Wine	☐ White Wine	☐ Liquor	☐ Other

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We ask that all patients to read and sign our financial policy. Should you have any question, please do not hesitate to speak with our billing department.

- **Cash patients**: Payment for services is due at the time services are rendered. We accept cash, card, and checks.

- **Insured patients**: Copayments, coinsurances, and/or deductibles are due at the time services are rendered. We accept cash, card and checks.

- If your insurance company does not pay your claim within 45 days, we ask that you contact your insurance company to help get your claim(s) for services paid.

- If the insurance company does not pay for the patients claim services, it is the patients responsibility to pay for the service.

- Returned checks are subject to a $50.00 returned check fee. If a check is returned, unpaid, it is the patient or guarantors responsibility to pay the balance,including the returned check fee, within 10 business days of notification to avoid further collection activity. Payment after the returned check will need to be paid by credit card or cash **ONLY**.

- Delinquent accounts will be turned over to a collection agency with 50% fee added to account balance. After a third and final statement is sent the account will be turned into the collection agency. All transactions will be between the patient/guarantor and the collection agency. All collection fees/court costs will be the responsibility of the patient/guarantor.

I have read and understand this Financial Policy.

_____ _____

Signature of Patient/Insured/Guarantor Date

DESERT CARDIOLOGY AND VASCULAR CENTER
CHANDRA R NARALA, MD
Clinical & Interventional Cardiologists
2847 St Rose Pkwy Suite #100 Henderson, NV 89052
Ph# (702) 947-5700 Fax# (702) 947-5703

MEDICAL RELEASE OF RECORDS

Patient's Name: _____ DOB: _____

I hereby authorize _____ to release medical records to:
(DOCTORS NAME OR FACILITY WHICH WE WILL REQUEST RECORDS FROM)

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REQUESTING FOR:

○ **STAT** **REQUESTED BY:_____**

___ALL MEDICAL RECORDS **___PROGRESS NOTES**

___ CATH REPORT **___ECHOCARDIOGRAM** **___CAROTID ULTRASOUND**

___LEA/LEV DOPPLER **___LABS** **___OPERATIVE REPORTS:_____**

___CTA CORONARY **___CTA CAROTID** **___LAST PROGRESS NOTES**

___RECENT STRESS TEST **___HEART MONITOR** **___SLEEP STUDY: PSG/CPAP**

___RECENT CARDIAC RELATED RECORDS

_____ _____
Patient's Signature Date

_____ _____
Legal Guardian Date

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MEDICAL RELEASE OF RECORDS

If you would like your family members or Doctors Office to have access to your medical records please list them below.

PATIENT NAME:_____ **DOB:**_____

FAMILY MEMBERS:

1._____ _____ _____ _____
LAST NAME FIRST NAME RELATIONSHIP CONTACT NUMBER

2._____ _____ _____ _____
LAST NAME FIRST NAME RELATIONSHIP CONTACT NUMBER

3._____ _____ _____ _____ _____ _____
LAST NAME FIRST NAME RELATIONSHIP CONTACT NUMBER

PROVIDERS:

1._____ _____ _____
PHYSICIANS NAME FACILITY NAME

_____
FACILITY ADDRESS

_____ _____
PHONE NUMBER FAX NUMBER

2._____ _____ _____
PHYSICIANS NAME FACILITY NAME

_____
FACILITY ADDRESS

_____ _____
PHONE NUMBER FAX NUMBER

3._____ _____ _____
PHYSICIANS NAME FACILITY NAME

_____
FACILITY ADDRESS

_____ _____