CARDIOVASCULAR CONSULTANTS, P.C.

10010 Donald S. Powers Dr., Munster, IN 46321 Ph: 219-934-4200 Fax: 219-934-4293
7217 Indianapolis Blvd., Hammond, IN 46324 Ph: 219-934-4290 Fax: 219-803-7596

Physicians

Wail Asfour, M.D., F.A.C.C., F.S.C.A.I.
Mohan Kesani, M.D.
P.R. Llobet, M.D., F.A.C.C.
Ravi Bhagwat, M.D., F.A.C.C.
Suhail Khadra, M.D., F.A.C.C.
Vinod Namana, M.D., M.P.H, F.A.C.C.

Nurse Practitioners

Donna Winterrowd, MS FNP-BC
Jessica Rayner, MSN, FNP-C
Carol Budgin, DNP, RN, CCNS
Kendra DeVries, MSN, FNP-C

Physician Assistant

Kelsey Morgan, BSHS, MSPA,
NCCPA Certified Physician Assistant

Patient Registration Form

(Please verify updated information and complete rest of required information)

Attending Physician: **Today's Date:**

Patient Information: Place of Birth: _____

Patient Name: Date of Birth: Pt. Account#:

Material Status: Sex: Male/Female SS#:

Primary Care Dr.:

Address: City: State: ZIP:

Home Phone: Work Phone: Cell Phone:

Employer Name: Employer Phone #:

Employer Address: City: State: ZIP:

Guardian Information: **(For Patients under 18)**

Name:

Home Phone: Work Phone: Cell Phone:

Additional Demographics:

Race (check box)

- o American Indian/Alaska Native
- o Asian
- o Black or African American
- o Native Hawaiian
- o White
- o Other Pacific Islander
- o More than one Race
- o Undefined//Refused to Report//Unreported

Ethnicity (circle)

Not Hispanic or Latino Hispanic or Latino Other: _____

Preferred Language (circle)

English Spanish Other: _____

Referring Physician Information:

Name: Phone:

Address: City: State: ZIP:

Emergency Contact Information:

Name: Phone #: Relationship:

Insurance Information:

Subscriber Information:

Name: DOB: SS#:

Address: City: State: ZIP:

Home Phone: Work Phone: Cell Phone:

Employer Name: Employer Phone:

Employer Address: City: State: ZIP:

Insurance Carrier: (Primary)---(Need copy of Insurance Card)

Name:

Plan: ID#: Group#:

Address:

Insurance Carrier: (Secondar) (IF ANY)— (Need Copy of Insurance Card)

Name:

Plan: ID#: Group#

Address:

Insurance Carrier (Tertiary) (IF ANY)— (Need Copy of Insurance Card)

Name:

Plan: ID#: Group#

Address:

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PATIENT HISTORY

Name: DOB:

PAST MEDICAL HISTORY: PLEASE Circle IF YOU HAVE A HISTORY OF THE FOLLOWING:

Abnormal Heart rhythm or EKG
Anxiety/Depression
Blood Clots
Blood Disease
Cancer (what kind)_____
Cardiomyopathy
Chest Pain
Congestive Heart Failure
Convulsions/Epilepsy
Diabetes
Emphysema/Asthma
Heart Murmur
Heart Attack
Heart Valve Disease
Hepatitis
Leg Pain/Cramps
High Blood Pressure (Hypertension)
High cholesterol/triglycerides
Leg circulation problems
Kidney Disease
Palpitations
Liver Disease
Rheumatic Fever
Stomach Ulcers
TIA/Stroke
Thyroid Disease
Shortness of breath
Swelling of extremities
Weight Gain
Weight Loss
Fainting/Lightheadedness

PAST SURGICAL/PROCEDURE HISTORY: PLEASE CIRCLE IF YOU HAVE A HISTORY OF THE FOLLOWING:

Aneurysm Repair
Angiogram
Blood Vessel Surgery
Carotid Surgery/Stent
Coronary Artery Bypass
Defibrillator Implant
Arterial Doppler
Heart Angioplasty/Stent
Heart Valve Surgery
Pacemaker Implant
Nuclear Stress Test
Echocardiogram
Carotid Doppler
Venous Doppler
Other:_____
_____

ALLERY TO MEDICATIONS: _____NO
_____YES

PLEASE LIST:_____
_____
_____

ALLERGY TO IODINE: _____NO
_____YES

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PATIENT NAME:_____

FAMILY MEDICAL HISTORY:

____Family History Unknown
____No family history of premature coronary disease (before age 65)
____No family history of sudden death

PLEASE INDICATE WHICH FAMILY MEMBERS HAVE HAD THE FOLLOWING:

	FATHER	MOTHER	SIBLINGS
Abnormal Heart Rhythm	____	____	____
Cardiomyopathy	____	____	____
Congestive Heart Failure	____	____	____
Coronary Artery Disease	____	____	____
Diabetes	____	____	____
Heart Attack	____	____	____
Peripheral Vascular Disease	____	____	____
Sudden Death	____	____	____
Valvar Heart Disease	____	____	____

SOCIAL HISTORY

Smoking/Use of tobacco products?

____Never Smoker
____Former Smoker Age Quit:_____
_____Smoker Age started:_____

Secondhand Smoke Exposure

_____No
_____Yes

Caffeine:

____Coffee
____Tea
____Soft Drinks
____Energy Drinks
____Drinks per Day
____Never caffeine use

Alcohol:

____Beer
____Wine
____Liquor
____Drinks per Day
____Never alcohol use

Drug Use:

____NEVER
____Yes

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Patient Name:_____

Pharmacy Name, Address, Telephone Number:_____

_____

Please list your medications, strength, and how often taken:

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