954 Teaneck Road, Teaneck, NJ 07666
Phone: 201-833-2300 | Fax: 201-833-7600
www.CardiovascularSpecialistsNJ.com

Stephen J. Angeli, MD, FACC
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Shalin P. Desai, MD

New Patient Information

Welcome to our office! Enclosed you will find our New Patient demographic form as well as our medical history form in their entirety. Please complete these forms as best you can and bring them with you on the day of your visit.

Medication: Please make sure to write down all of the medications, vitamins, and any supplements you may be currently taking on the included form. **Be sure to include dosages for all.**

Medical Records/Tests: If you have had any recent lab work, diagnostic tests, or any pertinent medical history, please try to obtain them from your physician(s) and bring them with you on the day of your visit. The history may also be mailed or faxed to our office to the information above.

Insurance/Referrals: Please bring your most recent insurance cards and photo identification with you on the day of your visit. Our physicians participate in several large insurance plans. ***Please note that it is the responsibility of the patient to obtain any necessary referrals or authorizations before your visit.*** **Please note that we will not be able to obtain referrals for you and your visit may be rescheduled or you will be responsible for your visit.**

Cancellations: If you cannot keep a scheduled appointment, kindly notify us with at least 24 hours' notice. If you must cancel your appointment due to last minute, unforeseen circumstances, please let us know as soon as possible.

After Hours, Weekends and Holidays: There is always a physician on call when our office is closed. Please note that this coverage is for **Emergencies only.** The answering service will handle all calls – please instruct the service that you wish to speak to the doctor on duty and leave your number. The doctor will respond as quickly as possible. Please be prepared to accurately describe your problem and all the medications you are taking.

In case of a life-threatening emergency, please call 911 to dispatch an ambulance.

Billing, Insurance, and Credit Information

Our business office billing representatives are available to assist you with any questions you may have. For billing inquiries, please call (201) 837-7003, option 7.

Please note that deductibles, co-insurances, and co-payments are the responsibility of the patient and these are ***due at the time of service.*** We cannot guarantee payment by any insurance carrier.

Privacy Policy: Our office complies with applicable laws regarding protection and confidentiality of sensitive medical records. Our Privacy Policy Notice is posted in our office and you may request a copy of this notice at any time.

Directions: From Route 4: Take Teaneck Road exit toward Ridgefield Park. We are the building on the right – our parking lot is after the blue-brick building.
From Route 80: Take Teaneck Road exit (70B) and travel through three traffic lights. Our building is on the left hand side before the blue-brick building.

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Notice of Information Practices and Privacy Statement for Cardiovascular Specialists of North Jersey

- **How we collect information about you:**

  Cardiovascular Specialists of North Jersey and its employees and volunteers collect data through a variety of means including but not necessarily limited to: letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

- **What we do not do with your information:**

  Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

  We do not give out, exchange, barter, rent, sell, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

- **How we do use your information:**

  Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication with **HNCA** and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance.

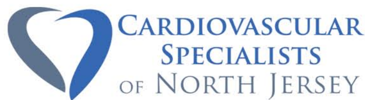
  If you apply or attempt to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

- **Limited Right to use non-identifying personal information from biographies, letters, notes, and other sources:**

  Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of the office. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

  Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

  You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.



CARDIOVASCULAR SPECIALISTS OF NORTH JERSEY

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PATIENT NAME:____
FIRST NAME MIDDLE INITIAL LAST NAME

STREET ADDRESS:____

CITY:______________________ STATE:__________________ ZIP CODE:____________

SEX: M☐ F☐ DO YOU RESIDE IN A SKILLED NURSING FACILITY? YES☐ NO☐ EMAIL ADDRESS:________________

HOME PHONE:____________________ CELL PHONE:____________________ WORK PHONE:________________

DOB:__________SS#:____________ MARITAL STATUS: S☐ M☐ D☐ W☐ NAME OF SPOUSE:________________

EMPLOYER:__________________________ EMPLOYER ADDRESS:______________________________

DO YOU HAVE A FLEX SPENDING ACCOUNT THROUGH YOUR EMPLOYER? YES☐ NO☐

EMERGENCY INFORMATION:

CONTACT PERSON____________________________________ RELATIONSHIP TO PATIENT:________________

HOME PHONE:____________________ CELL PHONE:____________________ WORK PHONE:________________

PRIMARY CARE PHYSICIAN:______________________ REFERRING PHYSICIAN/FRIEND:____________________

IF FULL-TIME STUDENT, INDICATE SCHOOL CURRENTLY ATTENDING:______________________________

PRIMARY INSURANCE:____

POLICY #:____________________________________ GROUP #:________________________________

ADDRESS:____ EFFECTIVE DATE:______________________

RELATIONSHIP TO INSURED:____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):________________________SS#__________DOB__________

SECONDARY INSURANCE:____

POLICY #:____________________________________ GROUP #:________________________________

ADDRESS:____ EFFECTIVE DATE:______________________

RELATIONSHIP TO INSURED:____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):________________________SS#__________DOB__________

WE WOULD LIKE TO KNOW HOW YOU HEARD ABOUT US? *(Please indicate below)*

☐ Patient at our office ☐ Yellow Pages ☐ Newspaper Ad ☐ Website
☐ Doctor/Primary Care MD ☐ Insurance Company ☐ Our Sign

Please supply us with your insurance card so we may photocopy it for our files.
Services must be paid at time of service if we do not participate with your insurance.

ASSIGNMENT OF BENEFITS: MY SIGNATURE BELOW INDICATES MY CONSENT FOR TREATMENT AND CONFIRMS MY UNDERSTANDING THAT ALL NON-COVERED ITEMS, CO-PAYMENTS AND DEDUCTIBLES ARE MY RESPONSIBILITY______________________ AND THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIMS THAT WAS ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO MY INSURANCE COMPANY. IF I AM UNCOVERED BY ANY INSURANCE, I AGREE TO PAY THE SELF-PAY FEE FOR THE SERVICES I RECEIVE.

SIGNED:____ DATE:

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND THE CENTER FOR MEDICARE AND MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNED:____ DATE:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PROVIDER OF SERVICE AND (OR) SUPPLIER FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER OF SERVICE AND (OR) SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICARE INFORMATION ABOUT ME TO RELEASE TO:

MEDIGAP INSURANCE:______________________________ HIC#____________________

ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED:____ DATE:

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HIPAA

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Right section describing your rights under the law. You have the right to review our Notice before signing this Consent.

The terms of our office may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about your is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing below, the patient acknowledges and understands that:

- ☐ Protected Health Information may be disclosed or used for treatment, payment, or health care operations.
- ☐ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- ☐ The Practice reserves the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- ☐ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- ☐ The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: ______________________ **Relationship to Patient** **(if other than patient):** _______
Printed Name – Patient or Representative

Signature: ______________________________________ **Signature Date:** _______________________

Witness: ______________________________
Printed Name – Practice Representative

Signature: ______________________________________ **Signature Date:** _______________________

PATIENT QUESTIONNAIRE

NAME: ____ DOB: ____/____/______ DATE: _____/____/_______

Who referred you to our office and why?		
List current medications, including over-the-counter and herbal preparations you have taken recently. Please indicate how many milligrams per dose and how many doses per day.		
Drug Allergies? If yes, explain: □ **Yes** □ **No**		
Any medical conditions/illness? If yes, explain: □ **Yes** □ **No**		
Any surgeries or hospitalizations? If yes, explain: □ **Yes** □ **No**		
Pharmacy Name and Phone Number:	**Do you smoke? If yes, how much?** □ **Yes** □ **No**	**Did you ever smoke? If yes, for how long ?** □ **Yes** □ **No**
Do you drink alcohol? If yes, how much? □ **Yes** □ **No**	**Do you use recreational drugs? If yes, please list?** □ **Yes** □ **No**	
Do you exercise? If yes, how much? □ **Yes** □ **No**	**Women only: Date of last menstrual period? _________** **Is there any possibility that you may be pregnant?** □ **Yes** □ **No**	
Height: / **Weight:**	**Age of Mother and Father? (If deceased, state cause)**	

Do you have a history of these conditions? **(Please mark all that apply)**

- ☐ **Hypertension**
- ☐ **Diabetes**
- ☐ **High Cholesterol**
- ☐ **Heart Attack**
- ☐ **Peripheral Vascular Disease**
- ☐ **Stroke or Mini-Stroke**
- ☐ **Coronary Artery Disease**
- ☐ **Congestive Heart Failure**

Does anyone in your family have any of the following?
If so, please specify which family member ***(i.e. mother, sibling, children, etc.)***
(Please mark all that apply)

- ☐ ***Heart Disease*** ________________
- ☐ ***Stroke*** ___________________
- ☐ ***High Blood Pressure*** __________
- ☐ ***Dementia*** ________________
- ☐ ***Diabetes*** ____________________
- ☐ ***Muscle Disorder*** ___________
- ☐ ***Cancer*** _____________________
- ☐ ***Sensory Disorder*** __________
- ☐ ***Arthritis*** ____________________
- ☐ ***Lack of coordination*** ________
- ☐ ***Bleeding Disorder*** _____________
- ☐ ***Shaking*** ________________
- ☐ ***Kidney Disease*** ________________
- ☐ ***Seizures*** _________________
- ☐ ***Thyroid Disease*** _______________
- ☐ ***Headaches***_______________
- ☐ ***Brain Tumors*** ________________
- ☐ ***Mental Illness*** _____________
- ☐ ***Aneurysm*** __________________
- ☐ ***Other*** ___________________
- ☐ ***Attention Deficit/Hyperactivity:***_________________________________

Comments: ____

____

Have you recently experienced any of the following?

Please use the bottom or back of this page to elaborate on any of these conditions (if needed).

- ☐ **Fever**
- ☐ **Nausea or Vomiting**
- ☐ **Weight Loss/Gain**
- ☐ **Chest Pain**
- ☐ **Change in Appetite**
- ☐ **Palpitations**
- ☐ **Visual Change**
- ☐ **Shortness of Breath**
- ☐ **Hearing Loss**
- ☐ **Allergies**
- ☐ **Earache**
- ☐ **Constipation**
- ☐ **Ringing in the Ears**
- ☐ **Diarrhea**
- ☐ **Cough**
- ☐ **Abdominal Pain**
- ☐ **Sore Throat**
- ☐ **Black or Tarry Stools**
- ☐ **Change in Smell**
- ☐ **Blood in Stools**
- ☐ **Difficulty Swallowing**
- ☐ **Problems Urinating**
- ☐ **Sexual Problems**
- ☐ **Difficulty Sleeping**
- ☐ **Joint Pain**
- ☐ **Anxiety**
- ☐ **Bone Problems**
- ☐ **Depression**
- ☐ **Neck/Low Back Pain**
- ☐ **Headaches**
- ☐ **Shooting Pain/Sciatica**
- ☐ **Change in Mental Ability**
- ☐ **Muscle Pain**
- ☐ **Memory Problems**
- ☐ **Skin Problem**
- ☐ **Hallucinations**
- ☐ **Bleeding or Bruising**
- ☐ **Agitation/Confusion**
- ☐ **Anemia**
- ☐ **Personality Changes**
- ☐ **Fatigue**
- ☐ **Difficulty Speaking**
- ☐ **Sleepiness/Sedation**
- ☐ **Change in Taste**
- ☐ **Dizziness/Vertigo**
- ☐ **Clumsiness**
- ☐ **Unsteadiness**
- ☐ **Weakness**
- ☐ **Numbness/Tingling**
- ☐ **Stiffness/Slowness**
- ☐ **Shaking**
- ☐ **Other** ___________________

MEDICATION LIST

Patient Name: ___________________________________ Date: ________

Please help us care for you better by telling us what prescription and over-the-counter medications you take and please this every time you visit. You may also bring in any prescription bottles.

Name of Medication	Dose (mg)	How many times per day	Who prescribed it for you? (Doctor's Name)

Over-the-counter Medications, Herbal Remedies, and Vitamins:

____

____

____