Southwest Cardiology
http://www.swcardiology.com

Calvert R. Busch, MD, FACC
Harvey S. Hahn, MD, FACC
Ziwar F. Karabatak, MD, FACC, FSCAI
Robert W. Kiefaber, MD, FACC, FSCAI

Ajay Reddivari, MD, FACC, FSCAI
Brian Schwartz, MD, FACC, FSCAI
David B. Stultz, MD, FACC
Frank J. Wenzke, MD, FACC

8057 Washington Village Dr.
Centerville , OH 45458-1847
Phone: (937) 312-9890
Fax (937) 312-9810

1380 E Stroop Rd.
Kettering, OH 45429-4926
Phone: (937) 294-4356
Fax (937) 297-2381

38 North Breiel Blvd.
Middletown, OH 45042-3804
Phone: (937) 422-5358
Fax (937) 422-4464

3533 Southern Blvd. Suite 2100
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Phone: (937) 293-3486
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Background

Name_____ Date of Birth:_____ Today's Date:_____

Primary Care Physician: _____

Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other:_____

☐ Retired Most Recent/Current Occupation:_____ Exercise:_____

Cardiac Risk Factors (Check all that apply)

☐ Hypertension (high blood pressure) ☐ Diabetes ☐ High Cholesterol ☐ Overweight/Obesity

Tobacco (packs per day): ☐ Never ☐ <½ ☐ ½-1 ☐ 1-2 ☐ >2 ☐ Quit Smoking Date:_____

Alcohol (drinks per day): ☐ None ☐ <1 ☐ 1-2 ☐ 2-3 ☐ >3 ☐ Quit Alcohol Date: _____

Caffeine (drinks per day): ☐ None ☐ <1 ☐ 1-2 ☐ 2-4 ☐ >4

Personal Past Cardiac History (Check all that apply)

☐ ***Coronary Artery Disease*** ☐ Myocardial Infarction (Heart Attack) ☐ Angina

Most Recent Heart Catheterization (Date & Hospital)_____

☐ Coronary Stent (Dates) _____ ☐ Angioplasty (Dates)_____

☐ Cardiac Bypass Surgery (Date)_____ ☐ Last Stress Test (Date/Place)_____

☐ ***Congestive Heart Failure*** Last Hospitalization for Heart Failure (Date & Hospital)_____

Most Recent Echocardiogram (Date & Location):_____Ejection Fraction:_____

☐ ***Peripheral Vascular Disease*** ☐ Stroke ☐ Transient Ischemic Attack (Mini Stroke) ☐ Carotid artery disease

☐ Abdominal Aortic Aneurysm ☐ Leg Claudication (Pain with walking)

☐ Vascular Surgery (type, date, place)_____

Other:_____

Valvular Heart Disease Aortic Valve: ☐ Stenosis ☐ Regurgitation

Mitral Valve: ☐ Prolapse ☐ Regurgitation ☐ Stenosis ☐ Rheumatic Fever

☐ Valve Surgery (Type of Valve, Date, Hospital):_____

Other:_____

Heart Rhythm Disorder ☐ Palpitations ☐ Atrial Fibrillation ☐ Atrial Flutter ☐ WPW

☐ Heart Block ☐ Syncope (passing out) ☐ Pacemaker (Type, date)_____

☐ Ablation Procedure (Type, Date & Hospital):_____

Other Cardiac Disease ☐ Myocarditis ☐ Pericarditis ☐ Pericardial Effusion ☐ Pulmonary Hypertension

☐ Other:_____

Personal Past Medical History (Please check conditions currently treated or treated in the past)

Lung disease:	☐ Asthma ☐ COPD or emphysema ☐ Sarcoid disease
	☐ Sleep Apnea ☐ CPAP use ☐ Pneumonia
Neurological diseases:	☐ Migraine headaches ☐ Seizure disorder ☐ Neuropathy
Liver disease:	☐ Hepatitis ☐ Liver failure (cirrhosis) ☐ Gallstones
Gastrointestinal disease:	☐ Gastroesophageal reflux disease (heartburn) ☐ Peptic ulcer disease
	☐ Chronic diarrhea ☐ Constipation ☐ Irritable bowel syndrome
Kidney disease:	☐ Renal failure ☐ Hemodialysis or Peritoneal dialysis
Autoimmune disease:	☐ Osteoarthritis ☐ Gout ☐ Rheumatoid arthritis ☐ Lupus arthritis ☐ Scleroderma
	☐ Immune deficiency (HIV, AIDS, or other)
Hematologic disease:	☐ Anemia ☐ Bleeding disorder ☐ Deep vein thrombosis (DVT) ☐ Pulmonary embolus (PE)
Oncologic disease:	☐ Cancer (type)_____
Cancer treatments:	☐ Chemotherapy ☐ Radiation ☐ Surgery
Endocrine disease:	☐ Thyroid disease ☐ Cushing's disease ☐ Addison's disease
Ophthalmologic disease:	☐ Glaucoma ☐ Cataracts ☐ Macular degeneration
Psychiatric:	☐ Depression ☐ Anxiety ☐ Other:_____

Other Personal Medical History

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Personal Past Surgical history (Please list type of surgery, approximate year)

☐ Gallbladder _____ ☐ Appendix _____ ☐ Tonsils _____ ☐ Hernia _____

Surgery	***Year***	***Surgery***	***Year***

Medication Allergies: _____ _____ _____ _____ _____

Current Medications You may attach a separate list. Include herbal remedies, aspirin, and vitamin supplements.

Medication	***Dose***	***How often***

Family History (Please list immediate family members – parents, siblings, children)

	Deceased	Age (if deceased, age at death)	Heart attack	Heart Failure	Heart Bypass Surgery	Hypertension	Stroke	Other
Father	☐	_______	☐	☐	☐	☐	☐	________________
Mother	☐	_______	☐	☐	☐	☐	☐	________________
___________	☐	_______	☐	☐	☐	☐	☐	________________
___________	☐	_______	☐	☐	☐	☐	☐	________________
___________	☐	_______	☐	☐	☐	☐	☐	________________
___________	☐	_______	☐	☐	☐	☐	☐	________________
___________	☐	_______	☐	☐	☐	☐	☐	________________
___________	☐	_______	☐	☐	☐	☐	☐	________________
___________	☐	_______	☐	☐	☐	☐	☐	________________
___________	☐	_______	☐	☐	☐	☐	☐	________________

Review of symptoms: Please check any symptoms you have had in the past 3 months

General:
- ☐ Change in appetite
- ☐ Persistent fever
- ☐ General fatigue
- ☐ General weakness
- ☐ Weight gain
- ☐ Weight loss
- ☐ Sensitivity to heat
- ☐ Sensitivity to cold
- ☐ Anxiety
- ☐ Depression

Eyes:
- ☐ Blurry vision
- ☐ Loss of vision
- ☐ Dry eyes

Ears, nose, mouth, throat:
- ☐ Loss of hearing
- ☐ Ringing in the ears
- ☐ Nosebleeds
- ☐ Dentures
- ☐ Sore throat
- ☐ Hoarseness

Cardiovascular:
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Fainting/loss of consciousness
- ☐ Blue fingers or lips
- ☐ Varicose veins

Respiratory:
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Pain with breathing
- ☐ Short of breath laying down

Endocrine:
- ☐ Adrenal disease
- ☐ Cortisone treatment

Genitourinary:
- ☐ Frequent daytime urination
- ☐ Frequent nighttime urination
- ☐ Pain or burning with urination
- ☐ (men) erectile dysfunction

Nervous system:
- ☐ Headaches
- ☐ Lightheadedness/dizziness
- ☐ Memory loss
- ☐ Weakness or paralysis

Gastrointestinal:
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal bleeding
- ☐ Tarry stools
- ☐ Jaundice
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Difficulty swallowing

Skin:
- ☐ Rash
- ☐ Loss of pigmentation
- ☐ Itching
- ☐ Dry skin
- ☐ Easy Bruising
- ☐ Skin Ulcers

Musculoskeletal:
- ☐ Muscle cramps
- ☐ Pain in joints
- ☐ Swollen joints
- ☐ Stiffness

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Supplemental Medication List

Name: _____ Date of Birth: _____ Today's Date: _____

Medication	*Dose*	*unit (mg)*	*How often*	*Comment*

Allergies

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Financial Policy

This Financial Policy has been established to clearly outline patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care while minimizing administrative costs.

- Patients who do not have insurance are expected to pay in full at the time of service unless prior arrangements have been made with us.
- Our office participates with numerous insurance companies and managed health care programs.
- It is the patient's responsibility to:
    1. Determine if our practice is in or out of their insurance network.
    2. Ensure that any required referrals for treatment are provided to the practice before the visit. Patients may be financially responsible if a required referral is not done.
    3. Know what pre-certifications may be required and ensure the requirements are met prior to the service.
    4. Provide us with current insurance information by presenting their insurance card(s) at each visit.
    5. Pay co-pays at the time of visit. An administrative charge of $10.00 will be added if the co-pay is not paid at the time of your visit
- Payment for professional services can be made with cash, check, MasterCard or Visa.
- All returned checks will have a processing fee of $35.00
- The office will submit a claim to your Primary and Secondary insurance, but the patient is ultimately responsible for the payment, regardless of insurance coverage. It is the patient's responsibility to submit Tertiary (Third) insurance claims. Please check with your insurance company for requirements.
- Our staff is happy to help with insurance questions regarding the processing of your claims. However, specific coverage issues can only be addressed by the insurance company's member services department whose number is on your card.
- All charges deemed patient responsibility by the patient's insurance shall be paid in full upon receipt of the first statement.
- It is the policy of Southwest Cardiology to provide a process for patients to meet their financial obligations to us. Please notify the receptionist if assistance is needed and you will be directed to the appropriate staff member.
- After review by the physician, patient balances aged 120 days on accounts with unfulfilled payment arrangements will be turned over to a collection agency and the patient will be discharged from the practice.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office. We are here to help you.

Please sign that you have read and agree to the SWC Financial Policy.

_____ _____ _____

Signature Print Name Date

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Patient Information

Last Name: _____ First Name: _____ Middle Initial:_____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (___)_____ Cell Phone (___)_____

Employer: _____ Work Phone (___)_____

Social Security #: _____ Date of Birth: _____ ☐ Male ☐ Female

Family Physician: _____ Referring Physician:_____

Emergency Contact

Name: _____ Relationship to Patient:_____

Home Phone: (___)_____ Work Phone: (___)_____

Primary Insurance

☐ Same as the patient information – patient is the Primary insurance subscriber

Subscriber Name: _____ Subscriber Date of Birth:_____

Subscriber Employer: _____ Subscriber Gender: ☐ Male ☐ Female

Secondary Insurance

☐ Same as the patient information – patient is the Secondary insurance subscriber

Subscriber Name: _____ Subscriber Date of Birth:_____

Subscriber Employer: _____ Subscriber Gender: ☐ Male ☐ Female

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to Southwest Cardiology, Inc. to render needed treatment to the above named patient.
2. I authorize Southwest Cardiology Inc to release any Information required for payment of claims.
3. I authorize payment of medical benefits to Southwest Cardiology Inc for services rendered.
4. I understand that I AM RESPONSIBLE for all charges incurred through Southwest Cardiology, Inc. Payment is expected at the time of my visit. If this cannot be done, I agree to pay any collection or attorney's fees incurred above and beyond the past due amount.

Signature: _____ Date: _____

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Notice of Privacy Practices

Southwest Cardiology, Inc. patient acknowledgment:

I hereby acknowledge that I was given a copy of the Notice of Privacy Practices issued by Southwest Cardiology, Inc. on the date indicated below.

_____
Signature

_____
Print or Type Name

_____
Date

_____
* Name of Patient (if different from above)

_____
* Relationship to patient

_____
Witness signature

_____
Date

Authorization for Telephone Contact

Due to the number of patients who have voicemail and/or answering machines, we need information about how to communicate with you.

Do you have an answering machine at your home? ☐ Yes ☐ No

If yes, may we leave a message regarding test results, appointments, surgery scheduling and/or billing matters? ☐ Yes ☐ No

Phone number:_____

Do you have voicemail at your job? ☐ Yes ☐ No

If yes, may we leave a message for you to return our call? ☐ Yes ☐ No

Phone number:_____

If you are not available, may we leave the above information with the spouse, relative, or another person? ☐ Yes ☐ No

If yes, list the name and phone number below:

Spouse _____

Phone _____

Other _____

Phone _____

Other _____

Phone _____

_____
Patient Signature Date