HEALTH QUESTIONNAIRE

PLEASE LIST BRIEFLY YOUR CURRENT MEDICAL PROBLEMS: **DURATION:**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

==========

PLEASE LIST YOUR CURRENT MEDICATIONS

1. _____ STRENGTH_____ TIMES PER DAY_____
2. _____ STRENGTH_____ TIMES PER DAY_____
3. _____ STRENGTH_____ TIMES PER DAY_____
4. _____ STRENGTH_____ TIMES PER DAY_____
5. _____ STRENGTH_____ TIMES PER DAY_____

ALLERGIES AND SENTITIVIES: _____

_____

HOSPITALIZATIONS & SURGERIES **YEAR** **HOSPITAL**

_____

_____

_____

FAMILY HISTORY: Has any blood relative ever had any of the Listed? Please Circle

Age	Disease	Age at Death
Father		
Mother		
Brother		
Sister		
Son		
Daughter		

Cancer	
Tuberculosis	
Diabetes	
Heart Trouble	
High Blood Pressure	
Stroke	
Convulsions	
Suicide	
Insanity	
Bleeding Tendency	

HABITS: (Circle One)

Alcoholic Beverage: Mild Moderately Heavy Never

Tobacco: Pack per Day_____ Duration_____ If Quit, When? _____

Coffee: Cups per Day: _____

NAME_____AGE_____SEX_____ DATE_____

PAST MEDICAL PROBLEMS (Please Circle) Write when

Rheumatic Fever	_____	**Bone Disease**	_____
Tuberculosis	_____	**Circulation**	_____
Lung Disease	_____	**Diabetes**	_____
Heart Disease	_____	**Strokes**	_____
Pneumonia	_____	**Cancer**	_____
Kidney Problem	_____	**Stomach Problem**	_____
Muscular Problem	_____	**Thyroid Problem**	_____
		Other	_____

SYSTEMIC REVIEW: **(Please Circle Yes or No as it applies to you.)**

GENERAL:

Recent Weight change: _____ YES NO

Have you been in good general health most of your life? _____ YES NO

SKIN:

Skin Disease_____YES NO

Hives, Eczema or Rash_____ YES NO

Jaundice_____YES NO

HEAD, EARS, EYES, NOSE, THROAT:

Eye Disease or Injury_____YES NO

Double Vision_____YES NO

Sneezing or Runny Nose_____YES NO

Chronic Sinus Trouble_____YES NO

Do you wear Glasses_____ YES NO

Headaches_____YES NO

Nosebleeds_____YES NO

Ear Disease_____ YES NO

RESPIRATORY:

Asthma or Wheezing_____YES NO

Upper Respiratory Infection_____YES NO

Chronic Cough or Cold_____YES NO

Difficulty Breathing_____YES NO

Spitting up Blood_____YES NO

CARDIO VASCULAR:

Chest pain or Angina Pectoris_____ YES NO

Heart Trouble or Heart Attacks_____ YES NO

Swelling of Hands, Feet or Ankles_____YES NO

Heart Murmur_____YES NO

Dizzy Spells, Black Outs_____YES NO

Palpitations/Heart Skips_____ YES NO

Difficulty Walking two Blocks ___YES NO

High Blood Pressure_____YES NO

Awakening in the Night Smothering_YES NO

Palpitation_____YES NO

Shortness of breath with walking or

Lying down_____YES NO

GASTROINTESTINAL:

Peptic Ulcer_____ YES NO

Vomiting Blood or Food_____YES NO

Gall Bladder Disease_____YES NO

Liver Trouble_____ YES NO

Hepatitis_____YES NO

Black Stools_____YES NO

Hemorrhoids or Piles_____YES NO

Recent change in Bowel Habits_____YES NO

Heartburn or indigestion_____YES NO

GENITOURINARY:

Burning or painful Urination_____YES NO

Blood in Urine_____YES NO

Kidney Trouble_____YES NO

Kidney Stone_____YES NO

GYNECOLOGICAL:

Number of Pregnancies_____

Number of miscarriages_____

Date of last Cancer Smear_____

LOCOMOTOR MUSCULOSKELETAL: Neuro Physc

Any pain in calves or buttocks on walking? YES NO

Muscular Weakness? YES NO

Have you ever had Psychiatric Care? YES NO

Have you ever had Convulsions? YES NO

HEMATOLOGIC:

Blood Disease_____YES NO

Anemia _____YES NO

Phlebitis_____YES NO

Have you had abnormal bleeding _____YES NO

Have you had abnormal Bruising_____YES NO

SIGNATURE_____ **DATE**_____

Patient Name: _____ Date: _____

General/Constitutional

Allergy Iodine/Shellfish	O Yes	O No
Weight gain	O Yes	O No
Weight loss	O Yes	O No
Fatigue	O Yes	O No

Ophthalmologic

Double vision	O Yes	O No
Blurred vision	O Yes	O No
Decreased visual acuity	O Yes	O No
Floaters in visual field	O Yes	O No

ENT

Chronic sinus trouble	O Yes	O No
Difficulty swallowing	O Yes	O No
Nosebleed	O Yes	O No

Endocrine

Diabetes	O Yes	O No
Cold intolerance	O Yes	O No
Thyroid problem	O Yes	O No
Heat intolerance	O Yes	O No

Respiratory

Asthma	O Yes	O No
Cough	O Yes	O No
Wheezing	O Yes	O No
Snoring	O Yes	O No
Cough Blood	O Yes	O No
Sleep apnea	O Yes	O No
Sputum production	O Yes	O No

Cardiovascular

Chest pain/ Discomfort	O Yes	O No
High blood pressure	O Yes	O No
Ankle swelling	O Yes	O No
Difficulty lying flat	O Yes	O No
Fluid in the legs	O Yes	O No
Heart Skipping	O Yes	O No
Heart murmur	O Yes	O No
Heart Trouble	O Yes	O No
Calf pain	O Yes	O No
Dizziness/Fainting	O Yes	O No
Irregular heartbeat	O Yes	O No
Shortness of breath	O Yes	O No
Unable walk 2 blocks	O Yes	O No
Jaw pain	O Yes	O No
Left arm/Neck pain	O Yes	O No
Weak/ Near faint	O Yes	O No

Patient Signature _____ Date _____

Patient Name: _____ Date: _____

Gastrointestinal

Gall bladder disease	O Yes	O No
Heartburn	O Yes	O No
Abdominal pain	O Yes	O No
Nausea	O Yes	O No
Blood in stool	O Yes	O No

Hematology

Easy bruising	O Yes	O No
Prolonged bleeding	O Yes	O No

Genitourinary

Blood in urine	O Yes	O No
Kidney problems	O Yes	O No
Difficulty urinating	O Yes	O No
Frequent urination	O Yes	O No

Musculoskeletal

Leg cramps	O Yes	O No
Muscle weakness	O Yes	O No
Painful joints	O Yes	O No

Skin

Hives	O Yes	O No
Skin disease	O Yes	O No

Neurologic

Transient vision loss	O Yes	O No
Stroke/ TIA	O Yes	O No

Psychiatric

Psychiatric disorder	O Yes	O No
Anxiety/ Depression	O Yes	O No
Substance abuse	O Yes	O No

Patient Signature _____ Date _____

HEMET HEART MEDICAL CENTER

Complete Cardiovascular Facility & Nuclear Cardiology Diagnostic Imaging Center

Anil Rastogi, M.D., F.A.C.C. Invasive & Interventional Cardiology

Gregory Riva, M.D. Electrophysiology

Anisha Rastogi, M.D. Interventional Cardiology

THE FOLLOWING INFORMATION IS NEEDED TO COMPLETE YOUR MEDICAL CHART

DATE_____

PATIENT NAME_____AGE_____BIRTHDATE_____

RACE_____ ETHNICITY_____ LANGUAGE_____

ADDRESS_____CITY_____STATE____ZIP_____

HOME PH _____CELL PH_____ EMAIL_____

PERMANENT RESIDENCE_____MARITAL STATUS (circle) M S W D SEX_____

OCCUPATION_____EMPLOYER_____

EMPLOYER ADDRESS_____

WORK PH_____SOC SEC #_____DRIVERS LIC #_____

SPOUSE'S NAME_____SPOUSE'S OCCUPATION_____

SPOUSE'S EMPLOYER ADDRESS_____

RESPONSIBLE PARTY (if other than patient)_____

NEAREST RELATIVE_____RELATIONSHIP_____PH_____

EMERGENCY CONTACT_____RELATIONSHIP_____PH_____

REFERRED BY_____PREVIOUS M.D._____

DO YOU HAVE AY DRUG ALLERGIES?_____

DO YOU HAVE MEDICARE? YES NO NUMBER_____

DO YOU HAVE OTHER INSURANCE? YES NO COMPANY/NUMBER_____

YOUR PHARMACY_____

NAME OF BANK & BRANCH AND OTHER CREDIT REFERENCES_____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

DATE_____ SIGNATURE_____

I hereby authorize Hemet Heart Medical Center to apply for benefits on my behalf for covered services rendered or ordered by him. I request that payment from my insurance company be made directly to Hemet Heart Medical Center. I understand that I am financially responsible for non-covered services by my insurance company.

I certify that the information I have reported with regard to my insurance coverage is correct.
I permit a copy of this authorization to be used in place of the original. Either my insurance company or myself may revoke this authorization at any time in writing.

DATE_____ SIGNATURE_____

1275 E. Latham Avenue · Suite A · Hemet, CA. 92543 ·Phone: (951) 652-5555 ·Fax:(951)766-2056

HEMET HEART MEDICAL CENTER

Complete Cardiovascular Facility & Nuclear Cardiology Diagnostic Imaging Center

Anil Rastogi, M.D., F.A.C.C.
Invasive & Interventional Cardiology

Gregory Riva, M.D.
Electrophysiology

Anisha Rastogi, M.D.
Interventional Cardiology

PATIENT RESPONSIBILITY/AUTHORIZATION AGREEMENT

FINANCIAL RESPONSIBILITY

Financial responsibility for services rendered rests with the patient and/or family. We are pleased to do insurance forms as a courtesy, but understand that it is still your responsibility to make certain that the bill is paid in a reasonable and prompt time. If for any reason, any portion of your bill is not paid by your insurance company, you must agree to make arrangements for prompt payment of the bill or contact your insurance company.

- **Co-Payment/Deductible:**

  You are responsible for your deductible and co-payment. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of service. Your co-payment is also due at the time of service.

- **Service Charges/Late Fees:**

  Any balance more than thirty days past due will be assessed a late fee of 5%. Those patients who arrange a payment plan will not be assessed any late fees.

COLLECTION RESPONSIBILITY

I understand that should Hemet Heart Medical Center send my account to a collection agency for attempting to collect a debt or recover any payments for services by Hemet Heart Medical Center, I am responsible for any extra costs requested by Hemet Heart Medical Center, or the COLLECTION AGENCY.

I, _____, acknowledge and understand the above.

AUTHORIZATION TO RELEASE INFORMATION

1275 E. Latham Avenue · Suite A · Hemet, CA. 92543 ·Phone: (951) 652-5555 ·Fax:(951)766-2056

HEMET HEART MEDICAL CENTER

Complete Cardiovascular Facility & Nuclear Cardiology Diagnostic Imaging Center

Anil Rastogi, M.D., F.A.C.C.
Invasive & Interventional Cardiology

Gregory Riva, M.D.
Electrophysiology

Anisha Rastogi, M.D.
Interventional Cardiology

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of my insurance benefits to be made on my behalf to:

Hemet Heart Medical Center
1275 East Latham Avenue, Suite A
Hemet, California 92543

I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible to Dr. Anil Rastogi, Dr. Gregory Riva, Dr. Anisha Rastogi for charges not covered by this authorization.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the above named physician to release any medical information necessary to process this claim.

Date_____

Signature_____ (Patient)

_____ (Insured's Name)

_____ (Insured's Social Security Number)

HEMET HEART MEDICAL CENTER

Complete Cardiovascular Facility & Nuclear Cardiology Diagnostic Imaging Center

Anil Rastogi, M.D., F.A.C.C.
Invasive & Interventional Cardiology

Gregory Riva, M.D.
Electrophysiology

Anisha Rastogi, M.D.
Interventional Cardiology

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Anil Rastogi for any services furnished by me or that physician or supplier.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim.

If other health insurance coverage is indicated in Item 9 of the HCGA-1500 Claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

In Medicare assigned cases, the Physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient responsible only for the deductible, co-insurance and non-covered services.

Co-Insurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature HIC Number

_____

Date

1275 E. Latham Avenue · Suite A · Hemet, CA. 92543 ·Phone: (951) 652-5555 ·Fax:(951)766-2056

HEMET HEART MEDICAL CENTER

Patient Consent to the Use and disclosure of Health Information
For treatment, Payment, or Healthcare Operations

I, _____ understand that as a part of my health care, Hemet Heart Medical Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of Communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of Healthcare professionals.

I understand and have been provide with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Hemet Heart Medical Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Hemet Heart Medical Center reserves the right to change their notice and practices and prior implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Hemet Healthcare Medical Center change their notice, they will send a copy of any revised notice to the address I've provided, (whether U.S. mail or, if I agree, email).
I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, answering machine, or a family member. I fully understand and accept/decline the terms of this consent.

_____
Patient's Signature

_____
Date

_____

_____

FOR OFFICE USE ONLY
[ ] Consent received by_____on_____
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on_____

HEMET HEART MEDICAL CENTER

Complete Cardiovascular Facility & Nuclear Cardiology Diagnostic Imaging Center

Anil Rastogi, M.D., F.A.C.C.
Invasive & Interventional Cardiology

Gregory Riva, M.D.
Electrophysiology

Anisha Rastogi, M.D.
Interventional Cardiology

WE HAVE A 24 HOUR CANCELLATION POLICY

IF YOU DO NOT CANCEL YOUR APPOINTMENT WITHIN 24 HOURS PRIOR TO YOU RAPPOINTMENT DATE AND TIME YOU WILL BE CHARGED $25.00

IF YOU REQUEST YOUR MEDICAL RECORDS, THERE WILL BE A CHARGE OF $15.00/MINIMUM

IF YOU BANK DOES NOT HONOR YOUR CHECK, THERE WILL BE A $25.00 CHARGE FOR RETURNED CHECK FEES.

IF WE PLACE A HOLTER MONITOR ON YOU AND YOU DO NOT RETURN YOUR HOLTER MONITOR FOR THE NEXT DAY (AS INSTRUCTED) THERE WILL BE A $25.00 PER DAY CHARGE FOR ADDITIONAL DAYS AFTER THE INITIAL 24-HOUR PERIOD. (WE NEED THE HOLTER RETURNED ON TIME FOR OTHER PATIENT USE)

I HAVE READ AND UNDERSTAND THE ABOVE:

_____ _____

NAME DATE

1275 E. Latham Avenue · Suite A · Hemet, CA. 92543 ·Phone: (951) 652-5555 ·Fax:(951)766-2056

HEMET HEART MEDICAL CENTER

Complete Cardiovascular Facility & Nuclear Cardiology Diagnostic Imaging Center

Anil Rastogi, M.D., F.A.C.C.
Invasive & Interventional Cardiology

Gregory Riva, M.D.
Electrophysiology

Anisha Rastogi, M.D.
Interventional Cardiology

Consent to obtain External Prescription History

I, _____, whose signature appears below, Authorize the Hemet Heart Medical Center and its Affiliated Providers to view my external prescription history via the RxHub Service.

I understand that prescription history from multiple other unaffiliated Medical providers, insurance companies, and pharmacy benefit Managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE ACCESS.

_____ _____

PATIENT DATE

_____ _____

WITNESS DATE

1275 E. Latham Avenue · Suite A · Hemet, CA. 92543 ·Phone: (951) 652-5555 ·Fax:(951)766-2056

HEMET HEART MEDICAL CENTER

Complete Cardiovascular Facility & Nuclear Cardiology Diagnostic Imaging Center

Amil Rastogi, M.D., F.A.C.C.
Invasive & Interventional Cardiology

Gregory Riva, M.D.
Electrophysiology

Anisha Rastogi, M.D.
Interventional Cardiology

PATIENT TERMINATION POLICY

Effective Immediately

Hemet Heart Medical Center providers and staff strive to create a pleasant working environment. We understand that there are times when you may be frustrated due to your current symptom(s) or personal situation(s). We will make every attempt to help you. However, this practice, under no circumstances, will tolerate:

- Verbal abuse for any reason.
- Physical abuse.
- Repeated failed appointments
- Patient refusal to go to the Emergency Room as directed by a provider.
- Failure to follow provider orders regarding labs or referrals.
- Patient failure to follow prescription medication orders or discontinuation of medications without notifying Hemet Heart Medical Center.

ANY VIOLATION OF THE ABOVE STATED CIRMCUMSTANCES OR ANY FORM OF ABUSE IS GROUNDS FOR *IMMEDIATE* DISCHARGE FROM HEMET HEART MEDICAL CENTER. (THIS INCLUDES ANY/ALL FAMILY MEMBERS ASSOCIATED WITH OUR PRACTICE).

Print Patient Name: _____ Date: _____

Patient Signature _____ Date: _____

1275 E. Latham Avenue · Suite A · Hemet, CA. 92543 ·Ph: (951) 652-5555 ·Fax :951)766-2056