HUMG-C: Advanced Cardiology Institute

The Center for Cardiac Diagnostics

Diplomates in Cardiovascular Disease

American Board of Internal Medicine

9W Office Center

2200 Fletcher Avenue

Fort Lee, NJ 07024

Walter D. Berkowitz, M.D., FACP, FACC
Howard C. Rothman, M.D., FACC
Nate E. Lebowitz, M.D., FACC
Jacqueline Hollywood, M.D., F.A.C.C.
Diane R. Zanger, M.D., F.A.C.C.
Steve S. Kim, M.D., F.A.C.C.
Tatiana Krasikov, M.D., F.A.C.C.

Tel (201) 461-6200
Fax (201) 461-7204
www.acicardio.com

Dear _____:

We would like to welcome you as a new patient to our practice. Enclosed are forms that you are required to complete prior to your appointment. These forms include a patient information sheet, a medical records request form (in order to retrieve any pertinent medical records from your previous physician), a HIPAA compliant waiver of consent form and important information about our facility and a medical history form. If another physician referred you, please bring any written referral/prescription or instructions that he/she may have given you. You should bring a detailed list of all of your current medications as well as any prior bloodwork, EKG or other cardiac testing you may have had done.

Please fill out the appropriate forms and present them to our receptionist when you arrive in our office. You are also required to present a copy of your insurance card/s and copayment (if applicable). If you have no insurance we ask that payment be made at the time of service. We accept Visa, Mastercard and American Express.

If you have been referred for diagnostic testing or if it is indicated following your initial examination, our facility is equipped to perform the following in our office: exercise stress test, echocardiogram, stress echocardiogram, carotid ultrasound, nuclear imaging, pacemaker interrogation, 24 hour blood pressure monitoring, ankle brachial indexing and holter monitoring.

We look forward to offering you our help and support, and we anticipate providing you with superior quality healthcare.

Sincerely,

Drs. Berkowitz, Rothman, Lebowitz, Hollywood, Zanger, Kim & Krasikov

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FROM THE EAST

George Washington Bridge

Lower Level: Exit 9W Fort Lee Palisades Parkway. Near right onto 9W/Fletcher Avenue. At first light make right into building driveway.

A Proceed straight toward building and turn right into second parking garage. Park in designated spaces on your left marked "ACI Reserved".

Upper Level: Exit Fort Lee-Lemoine/Center Avenue. At stop sign make wide turn onto Center Avenue.

B First light make left onto Bridge Plaza North. Pass one light and bear right onto 9W/Fletcher Avenue. At first light make right into building driveway. Follow directions from **A** above.

FROM THE WEST

Route 4: Exit Fort Lee/Palisades Parkway/9W, 1&9. 46 (at Hilton) follow ramp to light and make a left onto 9W/Fletcher Avenue. At second light make right into building driveway. Follow directions from **A** above.

Route 80 (local lanes only)**:** Exit Fort Lee/Palisades Parkway/9W, 1&9. 46 (at Hilton) follow ramp to light and make a left onto 9W/Fletcher Avenue. At second light make right into building driveway. Follow directions from **A** above.

FROM THE SOUTH

Take Anderson Avenue (two way): to Center Avenue (one way). Continue on Center Avenue until intersection of Bridge Plaza North making left and follow directions from **B** above.

FROM THE NORTH

From Palisades Interstate Parkway (PIP): Take exit 1 Palisade Avenue/Englewood. Exit bearing right. Make left at light onto 9W. Continue straight for 1 ½ miles. 9W bears right before overpass. Continue until second light make left into building driveway. Follow directions from **A** above.

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RE: ACI Policy on collection of Patient Identification Data

It is the policy of Advanced Cardiology Institute to collect preferably the social security number and/or the driver's license number of every patient seen in our office. This policy is intended to protect the patient from any potential insurance fraud. It is our responsibility as providers of medical care to ensure that your personal information is protected and to cut down on healthcare fraud and abuse which causes inflated healthcare premiums.

A patient will not be seen in this office without providing this information.

Thank you,

Joan Diore
Operations Manager

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INTRODUCTION

Advanced Cardiology Institute, The Center for Cardiac Diagnostics, is conveniently located in the heart of Fort Lee at the 9W Office Center 2200 Fletcher Avenue. Advanced Cardiology Institute consists of Diplomates in Cardiovascular Disease, American Board of Internal Medicine. Walter C. Berkowitz, M.D., F.A.C.P., F.A.C.C., Howard C. Rothman, M.D., F.A.C.C., Nate Lebowitz, M.D., F.A.C.C., *Diplomate, Certification Board of Nuclear Cardiology*, *Diplomate, National Board of Echocardiology*, Jacqueline Hollywood, M.D., F.A.C.C., *Diplomate, Certification Board of Nuclear Cardiology*, *Diplomate, National Board of Echocardiology*, Diane Zanger, M.D., F.A.C.C., Steve S. Kim, M.D., F.A.C.C. *Interventional Cardiology,* and Tatiana Krasikov, M.D, F.A.C.C.

Advanced Cardiology Institute uses the most contemporary equipment while maintaining traditional values. Convenient in-office diagnostic tests include nuclear stress testing, exercise stress test, EKG, echocardiogram, carotid ultrasound, holter monitor, 24 hour blood pressure monitor, stress echocardiography, pacemaker interrogations, phlebotomy and Coumadin tracking.

The facility and its staff recognize the diverse needs of the public and provide a quality blend of comfort and care which is unsurpassed. State-of-the-art equipment combined with a well trained and compassionate staff enables Advanced Cardiology Institute to continue to function as an important and vital part of the medical community.

In the event that our services are required we have enclosed a packet of referral sheets for your convenience. Please place our card in your rolodex for future reference and visit our website www.acicardio.com for more detailed information.
Thank you,

Advanced Cardiology Institute

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The Center for Cardiac Diagnostics

INTAKE FORM NEW PATIENT

Name: _____ **Exam Date:** _____

DOB: _____ **Age:** _____ **Sex:** _____

Primary MD: _____

PRIMARY MEDICAL HISTORY

Have you ever been diagnosed with (check all that apply):

- ☐ Heart attack
- ☐ Stroke
- ☐ Diabetes
- ☐ Hypertension
- ☐ High cholesterol
- ☐ Asthma/emphysema
- ☐ Sleep apnea
- ☐ Thyroid problem
- ☐ Anemia
- ☐ Stomach ulcers
- ☐ Blood in your stools
- ☐ Vomited blood
- ☐ Liver disease/hepatitis
- ☐ Kidney disease
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Skin disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Cancer type: _____
- ☐ Migraine headaches
- ☐ Seizures
- ☐ Hearing loss

PAST SURGICAL HISTORY

Have you had any surgeries?

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

SOCIAL HISTORY

Do you or have you ever smoked?

☐ Yes ☐ No ☐ Stopped:

Do you regularly drink alcohol?

☐ Rarely ☐ Socially # of glasses per week: _____

Employed? ☐ Yes ☐ No

Employer: _____ Position: _____

FAMILY HISTORY

Has anyone in your family (parents, siblings, children) suffered:

☐ Heart attack ☐ Stroke < 65 years old ☐ Sudden death (inexplicable)

Relationship: _____ Age: _____

Relationship: _____ Age: _____

Relationship: _____ Age: _____

FEMALE PATIENTS

Have you ever been pregnant?

Date: _____ Complications: _____
Date: _____ Complications: _____
Date: _____ Complications: _____
Date: _____ Complications: _____

ALLERGIES

Please list any allergies to medication(s).

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Shellfish: _____ Reaction: _____
Shellfish: _____ Reaction: _____

MEDICATIONS

Please list all of your current medications (including all over-the-counter medications) you take regularly.

_____ _____
_____ _____
_____ _____
_____ _____

RECENT HISTORY

Over the last 4 weeks, has your weight ☐ increased ☐decreased ☐ remained the same?

Over the past 4 weeks, have you experienced any of the following (check all that apply)?

☐ Fever	☐ Nausea	☐ Change in Urinary Habits
☐ Chills	☐ Vomiting	☐ Increased frequency of urination
☐ Fatigue	☐ Diarrhea	
☐ Runny nose/Nasal stuffiness	☐ Constipation	☐ Frequent urination at night
☐ Sinus congestion	☐ Chest pain	☐ Burning with urination
☐ Cough	☐ Palpitations	☐ Blood with stools or urine
☐ Shortness of breath	☐ Dizziness	☐ Skin rash
☐ Sore throat	☐ Fainting	☐ Joint Pain
☐ Blurred vision	☐ Swelling of your feet	☐ Muscle aches
☐ Significant daytime sleepiness	☐ Back aches	☐ Heavy snoring

Patient Signature: _____ **Date:** _____

Name: _____

Cardiac Testing:

Have you had the following? If yes provide year and result.

	Yes	No	Year	Positive	Negative
Exercise Stress Test	☐	☐	_____	☐	☐
Nuclear Stress Test	☐	☐	_____	☐	☐
Ultrasound of the Heart/Echo	☐	☐	_____	☐	☐
Stress Echocardiogram	☐	☐	_____	☐	☐
Carotid Ultrasound	☐	☐	_____	☐	☐
Ankle Brachial Indexing	☐	☐	_____	☐	☐
Holter Monitor	☐	☐	_____	☐	☐
24 Hour BP Monitor	☐	☐	_____	☐	☐

Family History: please underline applicable response

Father	deceased	alive and well	disease	age	_____
Mother	deceased	alive and well	disease	age	_____
Sister	deceased	alive and well	disease	age	_____
Brother	deceased	alive and well	disease	age	_____
Son	deceased	alive and well	disease	age	_____
Daughter	deceased	alive and well	disease	age	_____

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Patient Registration Form (Please Print) **Date: _____**

Patient Information

Patient's Last Name_____First Name_____

Street Address _____Apt. #_____ City _____ State _____Zip _____

Home Phone # (____) _____Work Phone # (____) _____Ext. _____

Cell Phone # (____) _____E-Mail _____ _____

Social Security # _____ Date of Birth _____/_____/_____ Age _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced Reason for Visit _____

Emergency Contact _____ Relationship _____ Telephone # _____

Pharmacy Name _____ City _____ Telephone # _____

How did you hear about our Practice? _____ _____

Due to new government regulations, this is a requirement. However, you have the option to refuse.

Ethnicity _____ Race: ☐ White ☐ African American ☐ Asian ☐ Hispanic ☐ Other
Language_____Refused __

Employer Information

Name of Employer _____Telephone #: _____

May we contact you at work? ☐ Yes ☐ No

Primary Insurance

Primary Insurance Name _____ Telephone #: (____) _____

Address _____City_____ State _____ Zip_____

Policy # _____ Group # _____ Effective Date _____/_____/_____ Co-Pay $ _____

Name of Insured _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Date of Birth _____/_____/_____ **Insured SS# _____**

Secondary Insurance

Secondary Insurance Name _____ Telephone #: (____) _____

Address _____City_____ State _____ Zip_____

Policy # _____ Group # _____ Effective Date _____/_____/_____ Co-Pay $ _____

Name of Insured _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Date of Birth _____/_____/_____ **Insured SS# _____**

Patient Privacy

In order to protect your privacy and in accordance with Federal law, we do not leave confidential medical information on answering machines or with anyone other than the patient or patient's legal guardian.

Please Indicate Below Your Preferences:

_____We may leave detailed messages on this answering machine # (_____) _____ _____
_____ Do not leave detailed messages on any answering machine
_____ You may leave messages with this/these:
Person/People _____ Telephone # ( )___ _____

1. I authorize the release of any medical information necessary to process my insurance claim(s) to Millennium Practice Management Associates, Inc.
2. I authorize and request payment of medical benefits directly to my physician(s) at HUMG-CP,
3. I agree that a photocopy of this form may be used in lieu of the original,
4. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles, co-payments, co- insurance and non-covered services.

X _____ _____/_____/_____|
Patient/Authorized Signature Date