The SWICFT Institute
625 9th Street North
Suite 201
Naples, FL 34102
239.261.2000 Phone
239.261.2266 Fax

James V. Talano, MD, MM, FACC
Peter R. Foster, MD, FACC
Sajan K. Rao, MD, FACC
Jennifer Mazorra, ARNP
Janet K. Sparker, PA-C, RN

Patient Information & Significant Medical History

Date _____

Patient Name _____ **Date of Birth** _____ **Sex** ____

Social Security Number _____ E-mail: _____

Local Address _____

Street City State Zip

Summer Address _____

(if applicable) Street City State Zip

Local Phone # _____ **Summer #** _____ Cell: _____

Occupation _____ Working currently? _____ If yes, Where? _____

Spouse's Name _____ **Work #**, if applicable _____

_____ **Race:** Black ____ White____ American Indian____ Asian ____ Native Hawaiian ___

Marital Status Single____ Married____ Widowed____ **Ethnicity:** ___ Not Hispanic or Latino ___Hispanic or Latino

# of children _____ **Ages** _____ Language _____

Referred by physician? yes____ no____ **Would you like us to send a report to them?** yes____ no____

Referring Physician _____ **Phone #** _____

Primary Care Physician _____

Primary Insurance _____ Policy # _____

Secondary Insurance (if applicable) _____ Policy # _____

Preferred Pharmacy _____ Preferred Laboratory _____

What is the chief problem that brings you to our office? _____

_____

_____

How long have you had this? _____

What do you think may be the cause? _____

Advance Directives

In the event that you become incapacitated and are unable to make decisions concerning your care have you made arrangements by:

completing a will? yes____ no____ (if yes, please bring a copy of your medical record) Where is it kept? _____

Designating a heath care surrogate decision maker? Yes____ no____ (if, yes, please complete)

Name Phone #

Past Medical History

Hospitalizations Year	Diagnosis	Surgery (if any)

Other Serious Illnesses Year	Diagnosis and Treatment

Medications List all medicines that you are taking: including vitamins, herbal, and over-the-counter drugs

Allergies List all medicines and other substances to which you are allergic and describe your reaction

Reaction is

Immunizations Pneumonia Vaccine (date) _____ Tetanus (date) _____ Flu (date) _____

X-Ray Studies Have you had any recent x-rays? Please list the study and the result

	Year	Result (if known)
Mammogram		
Chest		
Upper G.I.		
Lower G.I.		
Bone Density		

Family History List parents and all brothers and sisters (if deceased, list age at death and cause of death)

	Living?	Age	State of Health or Cause of Death
Mother			
Father			
Siblings			

Is there a family history of any of the following in a blood relative? Check all that apply

Alcoholism		Migraine		Diabetes		Epilepsy	
TB		Glaucoma		Stroke		Kidney Stones/Failure	
heart attack before 60		Nervous Breakdown		Valve problems			
High blood pressure		High cholesterol		High Homocysteine			
cancer		arrhythmias		CAD			

Personal Habits

	type	amount	If not now, have you ever?	when quit?
tobacco		per day ____ per week ____	yes ____ no____	
alcohol		per day ____ per week ____	yes ____ no____	
coffee,tea,colas		per day ____ per week ____		
special diet				

Activity Level

Independent with all daily activities	yes ____ no____	if need assistance, explain:
Require special assistance or equipment	no ____ yes____	
Completely dependent	no ____ yes____	
Exercise	no ____ yes____	hours per week

Pain

Are you presently or intermittently bothered by pain? yes ____ no ____

if yes: cause?

location duration

Would you describe the pain as: crushing____stabbing____tight____burning____

On a scale of 1-10, what is the intensity of your pain? ____

What relieves your pain?

Have you received an injury for which there is now a lawsuit pending? yes ____ no____

Is the purpose of this visit to determine the existence or extent of a disability? yes ____ no____

Have you had treatment with radiation? yes ____ no____

Nutritional Screen

Have you had a recent change in appetite? Explain _____

Any nausea, vomiting or diarrhea for more than 5 days? _____

Have you had an unintentional weight loss or gain of greater than 5 lbs in 1 month? loss ____ gain____

Do you have any of the following: How much in 1 month?_____

Fever or soaking sweats at night?	yes ____ no ____
Fatigue?	yes ____ no ____
Weakness or numbness of arms or legs?	yes ____ no ____
Headaches more than once or twice a week?	yes ____ no ____
Difficulty walking?	yes ____ no ____
Loss of consciousness or convulsions?	yes ____ no ____
Vision problems not corrected w/ glasses?	yes ____ no ____
Dizziness?	yes ____ no ____
Neck pain or stiffness?	yes ____ no ____
Frequent or sever nosebleeds?	yes ____ no ____
Sore tongue or mouth?	yes ____ no ____
Daily cough?	yes ____ no ____
Short of breath:	yes ____ no ____
Just sitting or lying down?	yes ____ no ____
After walking 2 flights of stairs?	yes ____ no ____
Discomfort in chest? Chest pain?	yes ____ no ____
Swelling of the ankles every day?	yes ____ no ____
Pain in legs when walking?	yes ____ no ____
High Blood Pressure?	yes ____ no ____
Abdominal Pain?	yes ____ no ____
Frequent heartburn or indigestion?	yes ____ no ____
Change in bowel habits?	yes ____ no ____
Black or bloody bowel movements?	yes ____ no ____
Nausea, or vomiting?	yes ____ no ____
Diarrhea?	yes ____ no ____
Bloody or unusual appearing urine?	yes ____ no ____
Difficulty urinating?	yes ____ no ____
Do you lose control of your urine at times?	yes ____ no ____
Awaken at night more than once to urinate?	yes ____ no ____
Do you snore?	yes ____ no ____
Excessively tired or sleepy during the day?	yes ____ no ____
Difficulty sleeping?	yes ____ no ____

Have you ever had?

Asthma	yes ____ no ____	Phlebitis	yes ____ no ____
Diabetes	yes ____ no ____	Pneumonia	yes ____ no ____
Cholesterol, High	yes ____ no ____	Polio	yes ____ no ____
Gonorrhea	yes ____ no ____	Rheumatic Fever	yes ____ no ____
Heart Murmur	yes ____ no ____	Stroke	yes ____ no ____
Heart Attack	yes ____ no ____	Sugar, High	yes ____ no ____
Hepatitis or Liver Disease	yes ____ no ____	Syphilis	yes ____ no ____
Herpes	yes ____ no ____	Thyroid Trouble	yes ____ no ____
Homocysteine, High	yes ____ no ____	Tuberculosis	yes ____ no ____
Kidney Stones	yes ____ no ____	Ulcer	yes ____ no ____
High Blood Pressure	yes ____ no ____		

Other Serious Illness not mentioned (please list below)

_____ _____

_____ _____

_____ _____

How do you learn best?

Listening to an explanation	yes ____ no ____
Seeing a picture with verbal and written instruction	yes ____ no ____
Watching a demonstration	yes ____ no ____
Watching a video	yes ____ no ____

Signature of Patient _____ Date _____

This certifies that I have been given the opportunity to view a copy of the SWICFT Institute's HIPPA (Privacy) practices.

Main Pharmacy Used: _____ Phone # _____

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Medical Records Request

I, _____ authorize _____
Name of Dr. we may get records from

_____
Street City State Zip

to RELEASE my medical information to:

SWICFT Institute
625 9th Street N, Suite 201
Naples, FL 34102

239-261-2000 Phone
239-261-2266 Fax

I request, as per my right through HPPAA regulations, that the above named office be granted the following information on my behalf:

- ✓ Cardioversions
- ✓ Catheter Procedures
- ✓ Echocardiograms or TEE's
- ✓ EKG's
- ✓ Lab Results
- ✓ Pacemaker/Defib Insertions
- ✓ Patient demographics
- ✓ Progress Notes
- ✓ Stress tests (Nuclear, Regular, or Echo)
- ✓ Valve Repair or Replacements
- ✓ Vascular or Pulmonary Studies

WITHIN the LAST 12 MONTHS OR MOST RECENT

Patient's Signature _____ Date _____

Date of Birth _____ Social Security Number _____

Witness _____ Position/Title _____

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This certifies that I have been given a copy of the SWICFT Institute's Notice of Privacy Practices for Protected Health Information (HIPAA) and Patient Privacy Rights.

Your physician also has remote access to the electronic medical record of the NCH Healthcare System and can view any testing or treatments provided to you at an NCH facility. Your permission is required to allow your physician remote access to your medical records. I therefore hereby authorize the physicians of the SWICFT Institute listed above access to my NCH medical record for care or treatment.

I am aware that I may contact the SWICFT Institute Privacy Officer at any time if I have questions regarding my personal chart and its contents.

_____ _____

Signature of Patient **Date**

_____ _____

Patient Name (Printed) **Date of Birth**

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FINANCIAL POLICY

Our charges for services are based upon the severity and complexity of your illness as well as the time spent treating you. In general, your initial visit will be more expensive than follow-up visits due to the collection of historical data and physical examination.

Payment for services rendered will be due at the time of service unless prior arrangements have been made. If you belong to a PPO insurance plan, etc. co-payments are to be paid at the time of service. We accept cash, check, Visa or MasterCard.

INSURANCE POLICY

Each patient must realize that professional services are rendered to you, not to your insurance company. Therefore, the insurance company is responsible to you, and you are ultimately responsible to us for professional service. We require insurance co-payment at the time of service. If you have no insurance, then payment is required in full, unless arrangements have been made.

Our services are covered by most PPO and other insurance plans. As each plan may differ, it is your responsibility to verify with your insurance company that our services will be covered before your appointment.

If you have questions regarding billing please contact our billing department at 239-325-2050

PAST DUE BILLS

If you currently have a past due balance on our account, the payment is expected in full prior to being seen by the Doctor. Payment arrangements my also be made for large balances. The patient will be responsible for contacting their insurance company if there is a dispute as to why they did not pay for services.

CANCELLATION POLICY

Our office requires 24-hour notification if the need to cancel your appointment arises. If this cancellation policy is not adhered to, the following action will be taken: First occurrence will prompt a warning reminding you of our policy. Second occurrence may result in a charge to you for the missed appointment. Please be aware that many insurance providers do not consider this as a covered expense in their plan, therefore you will be personally liable for this fee. Finally, it is our office policy to terminate medical services to patients who have missed appointments without 24-hour notification on three or more occasions.

I acknowledge that I fully understand the above statements and will comply with these policies.

_____ _____

Signature of Patient **Date**

_____ _____

Patient Name (Printed) **Date of Birth**