Welcome to AMELI | DADOURIAN HEART CENTER

Enclosed you will find a patient profile packet. Please complete these forms and bring them with you to your appointment. Please do not e-mail your forms to us. Completing these forms prior to your appointment time will make registration a faster process.

If you are seeing one of our physicians for the first time, you will not be considered a patient of our practice until you are actually seen by our physician.

Please arrive 15-20 minutes before your appointment time and allow the doctor to spend 45 minutes for your initial visit and 20 minutes for any follow up appointments.

You will need to bring all of your insurance cards and a photo ID. If you have seen another doctor in the past, please bring in your records.

If you have any questions, please contact our office at 702.906.1100.

We look forward to seeing you.

AMELI | DADOURIAN
HEART CENTER

PATIENT INFORMATION

Date: _____

Name: _____ Sex: M/ F Date of Birth_____ (mm/dd/yr.)

Social Security #_____/_____/_____ *Email: _____

Home: (_____) _____ Cell: (_____) _____ Work: (_____) _____

What is the best way to reach you? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail ☐ Text

Do you prefer: ☐ Detailed message ☐ Brief message

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Partner

Do you have an Advanced Directive? Yes / No.

Home Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Billing Address (If different than home address): _____

City: _____State: _____ Zip Code: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White/Caucasian ☐ Other ☐ I choose not to provide this

Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latino Primary Language: _____

Employer: _____ ☐ Retired Self Employed: ☐ Yes ☐ No

Work Address: _____ City: _____ State: ____ Zip Code: _____

Emergency Contact: _____Relationship: _____Phone:_____

Who is your Primary doctor (PCP)? _____ Phone: _____

Who is the referring Doctor? Name _____Phone: _____

*** By providing your email, you are providing permission for us to email you with educational information. We never sell, or share, your email address with anyone outside of Ameli | Dadourian Heart Center.**

AMELI | DADOURIAN
HEART CENTER

AUTHORIZATION FOR RELEASE OF PERSONAL AND HEALTH INFORMATION

Sean Ameli, MD Berge Dadourian, MD

In the event, we at Ameli | Dadourian Heart Center, may need to reach you, may we … *(check all that apply)*

- ☐ Leave a message with your spouse or family member.
- ☐ Speak only to you directly.
- ☐ Call you on your cell. The number is _____ - _____ - _____
- ☐ Call you at work. The number is _____ - _____ - _____

I, *(your/representative name)* _____ *(date of birth)* _____/_____/_____ *(mm/dd/yr),* give my Ameli | Dadourian Heart Center physician, staff, or representatives, authorization to disclose my protected health information and/or records to the following individuals and/or entities:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical records.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health and record information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices, which I obtained from my doctor's office. The following include limitations I would like to place on the use of this information:

_____

Unless, otherwise revoked, this authorization will expire on the following date, event, or condition:

_____. If I fail to specify a date this authorization will expire on (1) year from the signature on this form.

_____ _____

Signature of Patient Date

_____ _____

Signature of Guardian or Personal Representative Date

400 S. Rampart Blvd., Ste. 240 Las Vegas, NV 89145 PH: 702.906.1100 FAX: 702.906.1101 www.AmeliHeartCenter.com

AMELI | DADOURIAN
HEART CENTER

How did you hear about Ameli | Dadourian Heart Center?

☐ **Physician** ☐ **Insurance Plan** ☐ **Hospital** ☐ **Close to home/work**

☐ **Family** ☐ **Friend** ☐ **Other** ☐ **Marketing Source**_____

INSURANCE INFORMATION:

Primary Insurance: _____ **Insured:** ☐ **Self** ☐ **Spouse** ☐ **Other**

Subscriber: _____ **Date of Birth:** _____ **Policy or ID#:** _____

Group#: _____ **Social Security #:** _____ / _____ / _____

Secondary Insurance: _____ **Insured:** ☐ **Self** ☐ **Spouse** ☐ **Other**

Subscriber: _____ **Date of Birth:** _____ **Policy or ID#:** _____

Group#: _____ **Social Security #:** _____ / _____ / _____

Tertiary Insurance: _____ **Insured:** ☐ **Self** ☐ **Spouse** ☐ **Other**

Subscriber: _____ **Date of Birth:** _____ **Policy or ID#:** _____

Group#: _____ **Social Security #:** _____ / _____ / _____

Local Pharmacy	**Address or Cross Streets**	**Phone**	**Fax**
Mail Order Pharmacy	**Address**	**Phone**	**Fax**

Authorization and Assignment of Benefits

The above information is true to the best of my knowledge. I allow Ameli | Dadourian Heart Center to view prescription history from external sources. I allow Ameli | Dadourian Heart Center to obtain my results/records from radiology facilities, laboratory facilities, hospital facilities and any other medical providers. I hereby assign to the undersigned physician all payments for medical services rendered and authorize payment directly to them. I will be responsible for all non-covered services. I also authorize the physician to furnish information to insurance carriers concerning my illness and treatment. A copy of this original shall be valid as the original.

_____ _____

Signature of Patient, Parent, Guardian **Date**

AMELI | DADOURIAN
HEART CENTER

RECEIPT OF NOTICE TO PRIVACY PRACTICES

I, _____, understand that as a part of my health care, Ameli | Dadourian Heart Center originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, 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 provided with the *Notice of Privacy Practices* for Ameli | Dadourian Heart Center 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 this consent/disclosure.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Print Name of Patient	Date of Birth *(mm/dd/year)*
Signature of Patient	Date
Signature of Guardian or Personal Representative	Date
Signature of Employee	Date

AMELI | DADOURIAN
HEART CENTER

PATIENT & FINANCIAL AGREEMENT

_____ *(Initials)* Patients, or Responsible Party, are required to pay their co-pay and deductible at time of service.

_____ *(Initials)* I understand that services rendered to me by Ameli | Dadourian Heart Center are my financial responsibility and that the Provider will bill my insurance company, as a courtesy, and that it is my responsibility to know my coverage and eligibility benefits and to verify the physician's status (in-network, preferred, out-of-network, etc.).

_____ *(Initials)* I understand that I am, or my Responsible Party, is responsible for payment of my bill and there may be charges which my insurance may not cover, and which I, or Responsible Party, will have to pay. I authorize payment of medical benefits directly to Ameli | Dadourian Heart Center.

_____ *(Initials)* I understand that Ameli | Dadourian Heart Center is a participating physician in the Medicare program. I understand that Medicare patients are responsible for the annual deductible and the amount equal to 20% of the Medicare allowable. I also understand that I may be required to sign an Advance Beneficiary Notice of Non-coverage (ABN) and pay at the time of service

_____ *(Initials)* I understand that there will be a $50 charge for any checks returned for insufficient funds.

_____ *(Initials)* I understand in fairness to the other patients that a 24-hour notice is required for cancelling appointments and I may be charged a fee of $25.00 if not cancelled 24-hours in advance. I also understand that if I do not show for my appointments three times that I may be dismissed from the practice.

_____ *(Initials)* I understand that should my insurance company send payment to me, I will forward the payment to Ameli | Dadourian Heart Center within two business days. I agree that if I fail to send the payment in a timely way and the Provider is forced to proceed with the collections process; I, or Responsible Party, will be responsible for any cost and attorney fees incurred by Ameli | Dadourian Heart Center to retrieve their monies.

_____ *(Initials)* I understand it is my responsibility to provide accurate insurance information and to immediately report any changes in my insurance coverage.

_____ *(Initials)* I understand that it is my responsibility to contact my physician regarding any and all results after any testing is performed. I understand and acknowledge that I should request any prescription refills at the time of the office visit.

_____ *(Initials)* I understand it may take 24-48 hrs.to refill prescriptions and up to 72 hrs. for medical records to be completed.

_____ *(Initials)* I authorize the Provider to initiate a complaint to the appropriate department of insurance, the insurance commissioner, or department of managed care, for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

I have read and agree to all the provisions of the above financial and patient agreement.

_____
Print Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian or Personal Representative Date

AMELI | DADOURIAN
HEART CENTER

MEDICAL RECORDS RELEASE FORM

I hereby authorize and request records to be released

From: _____

To: Ameli | Dadourian Heart Center
400 S. Rampart Blvd.
Ste. 240
Las Vegas, Nevada 89145
Office: 702.906.1100
Fax: 702.906.1101

Requesting Physician: Sean Ameli, MD

Berge Dadourian, MD

_____
Print Name of Patient

Date of Birth *(mm/dd/year)* _____ / _____ / _____

Social Security Number _____ - _____ - _____

_____ _____
Signature of Patient Date

_____ _____

AMELI | DADOURIAN
HEART CENTER

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____ *(mm/dd/year)*

Do you have, or have you had, any of the following?

☐ Alcoholism	☐ Coronary Heart Disease	☐ High Blood Pressure	☐ Prostate Problems
☐ Anemia	☐ Crohn's Disease	☐ High Cholesterol	☐ Prosthesis
☐ Anxiety	☐ Deep Vein Thrombosis	☐ HIV	☐ Psychiatric Care
☐ Arthritis	☐ Defibrillator	☐ Impotence	☐ Pulmonary Embolism
☐ Asthma	☐ Depression/Feeling Blue	☐ Irritable Bowel Syndrome	☐ Rheumatoid Arthritis
☐ Atrial Fibrillation	☐ Diabetes Type I or II	☐ Kidney Disease	☐ Seizures
☐ Autoimmune Disease	☐ Dialysis	☐ Kidney Stones	☐ Sexual Issues
☐ Blood Disease	☐ Diverticulitis	☐ Liver Disease	☐ Sinus Trouble
☐ Breast Cancer/Lumpectomy	☐ Emphysema	☐ Melanoma	☐ Skin Cancer (non-melanoma)
☐ Breathing Problems	☐ Epilepsy	☐ Memory Problems	☐ Sleep problems/apnea
☐ Bronchitis	☐ GERD/Acid Reflux	☐ Migraine Headaches	☐ Stroke
☐ Bruise Easily	☐ Glaucoma	☐ Multiple Sclerosis	☐ Thyroid Disease _____
☐ Cancer _____	☐ Goiter	☐ Neurologic Disorder	☐ Tumors/Growths/Cysts
☐ Chemical Dependency	☐ Gout	☐ Osteopenia	☐ Urinary Tract Infections
☐ Chemotherapy	☐ Headaches	☐ Osteoporosis	☐ Vitamin Deficiency
☐ Chest Pains/Angina	☐ Heart Disease	☐ Pacemaker	☐ _____
☐ Cirrhosis	☐ Hepatitis Type _____	☐ Peripheral Vascular Disease	☐ _____
☐ Congestive Heart Failure	☐ Herpes	☐ Pneumonia	☐ _____

Women: Are You:

☐ Pregnant/ Trying to get pregnant ☐ Taking oral contraceptives ☐ Breastfeeding Last menstrual period _____

List any Injuries/Surgeries:	**Description:**	**Date:**
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

List Prescription and Over-the-Counter Medications:	**List Vitamins/Minerals/Herbs:**

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SOCIAL INFORMATION

Marital Status: Single / Married / Divorced / Widow / Partner

Name of Spouse/Partner: _____

Children:

Name _____ (M / F) _____ Age _____

Name _____ (M / F) _____ Age _____

Name _____ (M / F) _____ Age _____

Your Occupation: *(or past, if retired)* **_____**

Dietary Style: *(normal, diabetic, low fat, low salt, vegetarian, etc.)* **_____**

Physical Activity: *(type, how long, times per week)* **_____**

Tobacco Use: Yes / No / Stopped Age started: _____ Age stopped: _____

Product Type: _____ Amt. per day: _____

Alcohol Use: Yes / No If yes, Product Type: _____

How often: _____ How much: _____

Caffeine Use: Yes / No If yes, Product Type: _____

How often: _____ How much: _____

High Stress Level: Yes / No If yes, Reason: _____

Pharmacy:

Name of Pharmacy: _____ Phone Number: _____

Address: *(if unknown, what are the cross streets)* **_____**

Allergies:

Are you allergic to anything? Yes / No If yes, What: _____

Are you allergic to any of the following?

- ☐ **Bee stings**
- ☐ **Eggs**
- ☐ **Milk**
- ☐ **Seafood/Shellfish**
- ☐ **Contrast Dye/Iodine**
- ☐ **Latex**
- ☐ **Peanuts**
- ☐ **Statins**

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PATIENT FAMILY HISTORY

Name: _____ Date: _____

Family History: *Please list all significant illness, past and present.*

Biological Father:

Current age: _____ If deceased, age and cause of death: _____

Medical Problems: _____

_____

_____

_____

Biological Mother:

Current age: _____ If deceased, age and cause of death: _____

Medical Problems: _____

_____

_____

_____

Sibling: (M / F) _____ Age _____ Medical Problems: _____

_____

Sibling: (M / F) _____ Age _____ Medical Problems: _____

_____

Sibling: (M / F) _____ Age _____ Medical Problems: _____

_____

Sibling: (M / F) _____ Age _____ Medical Problems: _____

_____

Other medical problems that run in your family: *(condition and relatives affected)* _____

_____