ALAN KALISCHER,M.D. F.A.C.C.

INSURANCE INFORMATION AND AUTHORIZATION

PATIENT INFORMATION

PATIENT'S NAME:_____SOC.SEC___-___-____ D.O.B.:_____

HOME ADDRESS:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____ EXT:_____

AGE:____SEX:MALE/FEMALE RACE:_____MARITAL STATUS:MARRIED/SINGLE/WIDOWED/DIVORCED

EMERGENCY CONTACT:_____ EMERGENCY NUMBER:_____

EMAIL:_____

WORK INFORMATION:

EMPLOYER'S NAME:_____ EMPLOYER'S NUMBER:_____

EMPLOYER'S ADDRESS:_____CITY:_____STATE:____ZIP:_____

DOCTOR INFORMATION:

PRIMARY CARE PHYSICIAN:_____PHYSICIAN NUMBER:_____

PHYSICIAN ADDRESS:_____CITY:_____STATE:____ZIP:_____

RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING:

NAME:_____RELATIONSHIP:_____ NUMBER:_____

NAME:_____RELATIONSHIP:_____ NUMBER:_____

NAME:_____RELATIONSHIP:_____ NUMBER:_____

PRIMARY INSURANCE:

INSURANCE COMPANY:_____ID#_____

SECONDARY INSURANCE:

INSURANCE COMPANY:_____ID#_____

ASSIGNMENT,RELEASE,AND AUTHORIZATION:

I UNDERSTAND, AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DR.KALISCHER,MD,FOR ANY SERVICES FURNISHED BY HIM. I AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY OR ITS AGENTS ALL INFORMATION NEEDED TO REEVALUATE AND ADMINISTER CLAIMS. I AUTHORIZE THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO DR.KALISCHER,MD,FOR SERVICES FURNISHED BY HIM.
I AUTHORIZE DR.KALISCHER TO RELEASE ANY INFORMATION NEEDED TO EVALUATE CLAIMS TO THE HEALTHCARE FINANCING ADMIN.
I AUTHORIZE DR.KALISCHER TO PREFORM ANY OFFICE PROCEDURES HE DEEMS NECESSARY TO EVALUATE/TREAT MY CONDITION.
I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THE PRIVACY POLICY OF THIS OFFICE

X_____ DATE_____

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN

Fanwood-Westfield Cardiology, L.L.C

NEW PATIENT HISTORY FORM

NAME:_____ DATE:_____

DATE OF BIRTH:_____ REFERRING PHYSICIAN:_____

HOME PHONE:_____ CELL PHONE:_____

EMERGENCY CONTACT:_____ EMERGENCY CONTACT NUMBER:_____

PHARMACY:_____ PHARMACY NUMBER:_____

PHARMACY ADDRESS:_____CITY:_____STATE:_____ZIP:_____

DRUG ALLERGIES:_____ ARE YOU ALLERGIC TO CONTRAST DYE?YES/NO

MEDICAL HISTORY

DIABETES	YES/NO
HYPERTENSION	YES/NO
CANCER	YES/NO
STROKE/TIA	YES/NO
HEART DISEASE	YES/NO
BLEEDING TENDENCY	YES/NO
STOMACH PROBLEMS	YES/NO
MAJOR INFECTIONS	YES/NO
HEREDITARY DEFECT	YES/NO
LUNG PROBLEMS	YES/NO
KIDNEY PROBLEMS	YES/NO
LIVER PROBLEMS	YES/NO

IF YES EXPLAIN:

_____

_____

_____

PREVIOUS HOSPITALIZATIONS/SURGERIES: WHEN?

CURRENT MEDICATIONS:

SOCIAL HISTORY:

MARITAL STATUS: SINGLE/MARRIED/SEPARATED/DIVORCED/WIDOWED

ALCOHOL USE: YES/NO **HOW MUCH?** _____ DAY/MONTH/YEAR

TOBACCO USE: YES/NEVER/PREVIOUSLY **HOW MUCH?** _____ DAY/WEEK

SUBSTANCE ABUSE: YES/NEVER/PREVIOUSLY **HOW MUCH?**_____ DAY/WEEK **TYPE:**_____

EXPOSURE TO CHEMICALS? YES/NO **TYPE:**_____

EMPLOYMENT TYPE:_____ HOME LIFE:_____

EATING HABITS:_____ **SEXUAL ACTIVE:** YES/NO

EXERCISE:YES/NO **HOW MUCH**_____WEEK

FAMILY HISTORY:

	AGE:	DISEASES:
MOTHER:	_____	_____
FATHER:	_____	_____
SIBLINGS:	_____	_____
	_____	_____
CHILDREN:	_____	_____
	_____	_____

AUTHORIZATION FOR INSURANCE CARRIERS

I hereby authorize direct payments to Dr. Alan Kalischer for services rendered to me in the office, or hospital. I also understand that I am financially responsible for deductibles, copayments and services not covered by my insurance.

Signature_____ Date_____

Print Name_____ Date_____

BILLING AND INSURANCE INFORMATION

I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional collection fee of 20% of the balance of my account.

I agree to pay all the bank fees for any returned check due to insufficient funds.

If my insurance company requires referrals and I do not have one with me, at the time of my visit I will need to reschedule my appt. Referrals from my PCP are my responsibility.

Signature_____ Date_____

Print Name_____ Date_____