New Patient Registration Form

Cardiology

Dr. Ahmet Sayan, MD

Today's Date:_______________________ Account #_______________

Name: _______________________ DOB: __________ Preferred Language: _______________

Mailing Address:_______________________ Age: _______ E-Mail: _______________________

City, State, Zip: _______________________ SSN: _______________ Preferred Pharmacy: _______________

Home Phone: _______________ Cell Phone: _______________ Marital Status: Married ( ) Single ( ) Widowed ( ) Divorced ( )

In case of Emergency, Notify: _______________________ Sex: Male ( ) Female ( )

Phone: _______________________ Referred by: _______________________

Relationship to patient: _______________________ Phone: _______________________

Insurance Information

Primary Insurance: _______________________ Secondary Insurance: _______________________

ID Number: _______________ Group Number: __________ ID Number: _______________ Group Number: __________

Mailing Address: _______________________ Mailing Address: _______________________

City, State, Zip: _______________________ City, State, Zip: _______________________

Name/Policy Holder: _______________________ Name/Policy Holder: _______________________

SSN: _______________________ SSN: _______________________

DOB: _______ Relationship to Patient: _______________ DOB: _______ Relationship to Patient: _______________

Employment Information

Employer: _______________________ Telephone: _______________________

Mailing Address: _______________________ City, State, Zip: _______________________

Responsible Party Information

Name: _______________________

Mailing Address: _______________________

City, State, Zip: _______________________

DOB: _______ E-Mail: _______________________

SSN: _______________________

As the responsible party, I agree that all charges that are not directly paid by the insurance company will be my responsibility

X _______________________

Responsible Party Signature

Phone: _______________________

Payment of Benefits

I authorize payment of benefits, as determined by the insurance company, directly to the physician's office. I understand that I still may be responsible for any amounts not paid by my insurance company.

Signature: _______________________ Date: _______________

Medical Release Authorization

I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that all information on this form is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature: _______________________ Date: _______________

Cancellation of Scheduled Appointments

I understand that if I have a serious emergency and I am unable to come to my appointment, I will contact the office as soon as possible. In other cases, if I fail to cancel my appointment 24 business hours in advance, I will be charged $50.00 for the missed appointment.

Signature: _______________________ Date: _______________

St Thomas Location:
9149 Estate Thomas, Ste 104
St. Thomas, VI 00802
PH: 340.714.2845
FX: 340.714.2843

St Croix Location:
4423 Estate Mary's Fancy
Christiansted, VI 00820
PH: 340.692.5000
FX: 340.692.5002

Cardiology | Orthopaedics | Pain Management | Rheumatology
Rehabilitation | Wellness | Wound Care

CARDIOLOGY INTAKE FORM

Name:	**Date:**

Referring Provider:	**Preferred Pharmacy:**

Reason for today's visit:

Please Check Off if you have any of the following MEDICAL HISTORY:

- ☐ **Hypertension**
- ☐ **High Cholesterol (Hyperlipidemia)**
- ☐ **Diabetes**
- ☐ **Smoking history**
- ☐ **Heart Attack: Date:__________. Where: ___________________________.**
- ☐ **Murmur/Heart valve disease**
- ☐ **Congestive Heart Failure (CHF)**
- ☐ **Atrial Fibrillation (AFIB)**
- ☐ **Palpitations**
- ☐ **Peripheral Artery Disease (PAD)**
- ☐ **Abdominal Aortic Aneurysm (AAA)**
- ☐ **Stroke (CVA) or TIA: Date: __________.**
- ☐ **Kidney problems**
- ☐ **COPD**
- ☐ **Asthma**

Any other Past MEDICAL HISTORY:

VIRGIN ISLANDS VIC CARDIOLOGY

St Thomas Location:
9149 Estate Thomas, Ste 104
St. Thomas, VI 00802
PH: 340.714.2845
FX: 340.714.2843

St Croix Location:
4423 Estate Mary's Fancy
Christiansted, VI 00820
PH: 340.692.5000
FX: 340.692.5002

Cardiology | Orthopaedics | Pain Management | Rheumatology
Rehabilitation | Wellness | Wound Care

Please Check Off if you have had any of the following SURGICAL PROCEDURS:

- ☐ Coronary Bypass (CABG): Date: ___________. Where: _____________________________.
- ☐ Valve replacement: Date: ___________. Where: _____________________________.
- ☐ Coronary Stents: Date: ___________. Where: _____________________________.
- ☐ Ablation: Date: ___________. Where: _____________________________.
- ☐ Pacemaker: _________ Date: ___________. Where: _____________________________.
- ☐ Defibrillator: _________ Date: ___________. Where: _____________________________.

Any other Past SURGERIES/OPERATIONS:

Please Check Off if you had any of the following CARDIAC TESTING:

- ☐ Stress Test: Date: ____________. Where: ______________________.
- ☐ Echocardiogram (ECHO): Date: ____________. Where: ______________________.
- ☐ Cardiac Catheterization: Date: ____________. Where: ______________________.

Please Check Off if you have any of the following SYMPTOMS:

- ☐ Chest Pain: Is it worse with exertion? Circle: Yes/No.
  Is it worse at night? Circle: Yes/No.
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Edema/swelling of feet
- ☐ Dizziness

Family History of Heart Disease: **Circle: Yes/No. If so, who: ___________________.**

Smoking History: **Circle: Yes/No. If previous smoker: Quit Date: ______________.**

Alcohol Use: **Circle: Yes/No. If yes, how often: __________________________.**

MEDICATIONS:

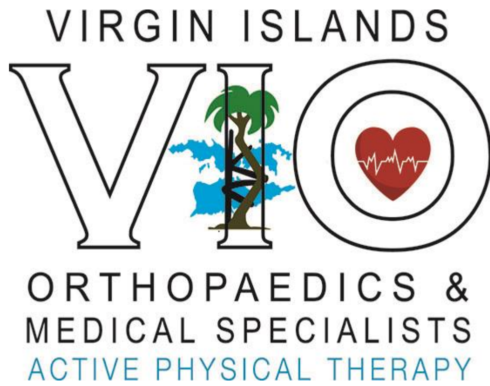
Medication Name:	Dosage:	Frequency:

Medication Allergies: Circle: Yes/No. If so, which medication(s): ____________________________.

Personal Information:

Birthplace:	Employment:
Marital Status:	Children:

Thank you!
Dr. Sayan
VI Cardiology



St Thomas Location:
9149 Estate Thomas, Ste 104
St. Thomas, VI 00802
PH: 340.714.2845
FX: 340.714.2843

St Croix Location:
4423 Estate Mary's Fancy
Christiansted, VI 00820
PH: 340.692.5000
FX: 340.692.5002

Cardiology | Orthopaedics | Pain Management | Rheumatology
Rehabilitation | Wellness | Wound Care

Cancellation Policy/No Show Policy

For Doctor Appointments and Surgery

1. **Cancellation/ No Show Policy for Appointment**
   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a ***fifty-dollar ($50) fee***; this will not be covered by your insurance company.
2. **Scheduled Appointments**
   We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we may have to reschedule the appointment.
3. **Cancellation/ No Show Policy for Surgery**
   Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. If surgery is not cancelled at least 10 days in advance you will be charged a ***two hundred dollar ($200) fee***; this is will not be covered by your insurance company.
4. **Account balances**
   We will require that patients with self-pay balances do pay their account balances to ***zero (0)*** prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

________________________ ________________________ ____/____/____

Print Name Patient **Signature Patient/Guardian** **Date**

Patient Account #____________________

(Office Use Only)