Cenla Heart Specialists

Harry R. Hawthorne, M.D.   Dinesh Shaw, M.D.   Navtej S. Rangi, M.D.
Vikram Nijjar, M.D.   Reymond Meadaa, M.D.

Name:______________________________ Age:________ Date:________________

Family Doctor:______________________________ Referring Doctor:______________________________

Why are you seeing the doctor today?____

____

____

Do you have any other medical problems?	Yes	No
High Blood Pressure	❑	❑
Heart Trouble, Chest	❑	❑
Diabetes	❑	❑
Liver Disease, Hepatitis	❑	❑
Asthma	❑	❑

Any other problems, please list ____

____

____

What types of medicines do you take?	What dosage?
1) ______________________________	________________
2) ______________________________	________________
3) ______________________________	________________
4) ______________________________	________________

Are you allergic to any medicines? ❑ Yes ❑ No

If yes, which ones?____

____

Have you had any previous surgeries? If so, what for and when? List:______________________

____

____

____

Do you smoke? If so, how much?____

Do you drink alcohol? If so, what quantity?______________________________________

2108 Texas Avenue, Suite 2061, Alexandria, Louisiana 71301 • P.O. Box 12484 • Alexandria, Louisiana 71315
Phone (318) 448-1041 • Fax (318) 487-4596
2108 Texas Avenue, Suite 3062, Alexandria, Louisiana 71301 • Phone (318) 448-0858 • Fax (318) 442-9765

CENLA HEART SPECIALISTS, LLC
2108 Texas Ave
Suite 2061
Alexandria, LA 71301-3944
USA
(318) 448-1041

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)	ETHNICITY

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	SECONDARY HOME PHONE	RACE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	SECONDARY HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

Please read and sign the following: I request that the payment of authorized Medicare and/or Insurance benefits are made to Cenla Heart Specialists for any services furnished to me by the Physicians. I authorize any holder of medical information about me to release to my insurance carrier and/or heath care financing administration and its agents any information needed to determine these benefits payable for related services.

IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT,CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE.

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________________