

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: _____

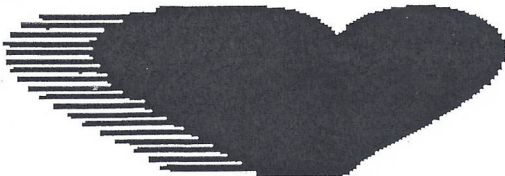
Do you smoke? If so, how much? _____

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

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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 health 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