SIDNEY PEYKAR, M.D., F.A.C.C.

CLINICAL CARDIAC ELECTROPHYSIOLOGY
COMPLEX ARRHYTHMIA ABLATION
AND CARDIAC DEVICES

TEL: 1 (800) 771-7164 ❖ FAX: 1 (800) 773-7581 ❖ WWW.CAIFL.COM

SARASOTA MEMORIAL HEART & VASCULAR INSTITUTE ❖ 1540 SOUTH TAMIAMI TRAIL ❖ SUITE 305 ❖ SARASOTA, FLORIDA 34239
PEACE RIVER REGIONAL MEDICAL CENTER ❖ 2525 HARBOR BOULEVARD ❖ SUITE 203 ❖ PORT CHARLOTTE, FLORIDA 33952

LAST NAME:________________________ FIRST ____________________ MI____________

ADDRESS:______________________________________CITY:________________________

STATE:______________________________________ ZIP CODE:________________________

SECONDARY ADDRESS:____________________________CITY:________________________

STATE:______________________________________ZIP CODE:________________________

DATE OF BIRTH :________________________________HOME PHONE (   )______________

EMPLOYED BY:__________________________________WORK PHONE (   )______________

SOCIAL SECURITY #______________________________ DRIVER LICENSE ________________

MARITAL STATUS (CIRCLE ONE) M S W D SINGLE SEX (CIRCLE) MALE FEMALE

SPOUSE'S FULL NAME ______________________________ SPOUSES DOB____________

SPOUSES SOCIAL SECURITY#__________________________WORK# ____________________

EMERGENCY CONTACT__________________________RELATIONSHIP____________________

PHONE #(   )____________________ PASSWORD______________________________

REFERRED BY______________________________ PRIMARY DOCTOR____________________

PERSON RESPONSIBLE FOR PAYMENT______________RELATIONSHIP____________________

INSURANCE INFORMATION

PRIMARY INSURANCE____

INSURED'S NAME____

INSURED'S DATE OF BIRTH ________________ SOCIAL SECURITY#______________________

SECONDARY INSURANCE____

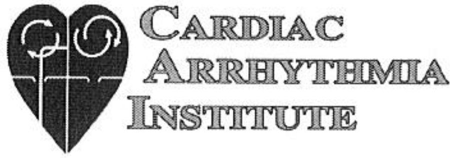
INSURED'S NAME____

INSURED'S DATE OF BIRTH ________________SOCIAL SECURITY#______________________

PATIENT PAYMENT RESPONSIBILITY I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL OFFICE AND HOSPITAL COPAYMENTS, DEDUCTIBLES, AND CO-INSURANCE PAYMENTS. FEES ARE DUE AT TIME OF SERVICE.

AUTHORIZATION AND ASSIGNMENT I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO SIDNEY PEYKAR, M.D FOR PROFESSIONAL SERVICES RENDERED. I AUTHORIZE SIDNEY PEYKAR, M.D TO RELEASE ANY INFORMATION NECESSARY TO REQUEST CLAIM REIMBURSEMENT FROM MY INSURANCE CARRIES(S)

SIGNATURE____ DATE____________________



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Peace River Regional Medical Center ⋄ 2525 Harbor Boulevard ⋄ Suite 203 ⋄ Port Charlotte, Florida 33952

Name____

Have you ever have or been Diagnosed with the following, If yes when

Rheumatic Heart Disease___ No ___Yes Year____

High Blood Pressure ___ No ___Yes Year_____

Kidney Stones___ No ___Yes Year____ COPD___ No ___Yes Year_____

Diverticulitis___ No ___Yes Year_____ Ulcers___ No ___Yes Year_____

Hyperlipidema___ No ___Yes Year_____ Phlebitis___ No ___Yes Year_____

Rheumatic Fever ___ No ___Yes Year____ Stroke___ No ___Yes Year_____

Gallstones___ No ___Yes Year_____ Heart Attack___ No ___Yes Year_____

Sleep apnea ___ No ___Yes Year____ Arthritis___ No ___Yes Year_____

Hiatal Hernia___ No ___Yes Year____ Cataracts___ No ___Yes Year_____

Glaucoma___ No ___Yes Year____ Liver Problems___ No ___Yes Year_____

Gout___ No ___Yes Year_____ Thyroid___ No ___Yes Year_____

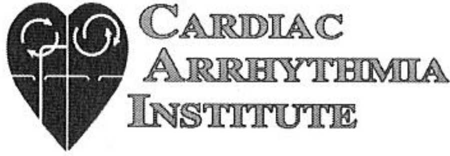
Past Surgeries and the date when you had the procedure

1.____ Date_____

2.____ Date_____

3. ____ Date_____

4. ____Date______



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Name: ____

Family History Any Cardiac Related Problems

Mother : Alive / Deceased ____

Father : Alive / Deceased_____ ____________________________________

Other Family members with cardiac related problems:

____

____

Social History

Do You Smoke ___ No ____ yes If yes how often _____________

if you Quit when ________

Alcohol ____ No ____ yes If yes how often _____________

Allergies

1.___________________________ Reaction ___________________________

2.___________________________ Reaction ___________________________

3.___________________________ Reaction ___________________________