REGISTRATION INFORMATION

BRING THIS ON DAY OF YOUR APPOINTMENT DO NOT MAIL OR FAX IN

****** PLEASE PRINT (BLACK INK ONLY) ******

Date_____ Home Phone_____

Cell Phone _____

Patient _____
(Last Name) (First Name) (Initial)

Responsible Party (if a minor) _____

Street Address _____

City_____ State _____ Zip _____

Sex ◇ M ◇ F Age_____ Birth date_____ ◇ Single ◇ Married ◇ Divorced ◇ Widowed

◇ Employed ◇ Full-time Student ◇ Retired Email Address: _____

Patient Employed By_____

Business Address _____

Occupation_____ Business Phone_____

Name of primary insured_____ Birth date_____

Relationship to patient_____

***Social Security #**_____ Spouses social security #_____

Do you have Medical Insurance? ◇ Yes ◇ No

Name of Primary Insurance _____

Insurance ID #_____ Group #_____

Name of secondary insurance_____

Insurance ID#_____ Group #_____

Is your condition related to employment? (current or previous) ◇ Yes ◇ No

Is your condition related to an auto accident? ◇ Yes ◇ No In which state? _____

Other accident? ◇ Yes ◇ No If yes, _____

Emergency contact name and relationship: _____

Phone number (**please provide a different number than above**) _____

Emergency contact

Please list name of Primary or referring doctor:

_____ _____

(General Practitioner, Specialist, or other) City/ Phone number

Reason for cardiology visit_____

How did you learn of our practice? _____

Whom may we thank for referring you? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____

(Name of Insurance Company)

and assign directly to Premier Cardiology, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

(Signature of Insured/Guardian) (Date)

MEDICARE AUTHORIZATION

I request that payment of Medicare benefits are made on my behalf to Premier Cardiology, for any services furnished to me by their physician's.

I authorize Premier Cardiology to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA- 1500 form, or elsewhere on other approved claim forms or electronically submitted claim, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

(Beneficiary Signature) (Date)

PREMIER CARDIOLOGY HAS ESTABLISHED A FIRM 'NO-SHOW' POLICY.
EFFECTIVE JANUARY 1, 2014,
A CHARGE OF $25. WILL BE MADE FOR ALL FAILED OR CANCELLED APPOINTMENTS WITHOUT A MINIMUM OF 2 BUSINESS DAYS' NOTICE

PLEASE SIGN AND DATE BELOW TO VERIFY YOUR UNDERSTANDING OF THE 'NO-SHOW' POLICY:

_____ _____

Signature Date

_____

Print Name

PREMIER CARDIOLOGY- PATIENT QUESTIONAIRE

Patient Name: _____ Primary Physician_____

Today's Date: _____

Current Problems/ Chief Complaints _____
_____
_____

CORONARY ARTERY DISEASE RISK PROFILE: Please answer the following questions.

Smoking:
Have you ever smoked? ☐ No (skip to next section) ☐ Yes
How many years have you smoked? ____
Average packs per day____
Do you still smoke? ☐ Yes ☐ No- What year did you stop? ____

High blood pressure:
Has you blood pressure ever been high? ☐ NO (skip to next section) ☐ Yes
Have you ever been treated for high blood pressure? ☐ Yes ☐ No How many years? _____
Are you taking medicines now for high blood pressure? ☐ Yes ☐ No

Diabetes mellitus:
Have you ever been told you have diabetes? ☐ No (skip to next section) ☐ Yes
Are you treated now for diabetes? ☐ Yes ☐ No How many years? _____
If yes, with ☐ diet ☐ oral medications ☐ insulin
How many years has your diabetes been treated? _____ Years

High cholesterol
Has your cholesterol been high? ☐ No (skip to next section) ☐ Yes
Enter your most recent values if known: Cholesterol_____ HDL _____ LDL _____ Triglycerides _____
Are you on medications for cholesterol? ____ Yes _____ No

Family history of coronary disease:
Is there coronary disease in your family? (angina, heart attack, angioplasty or bypass)? ☐ Yes ☐ No

Relative_____ Age when problem started_____ Problem(s) _____

Relative_____ Age when problem started_____ Problem(s) _____

Relative_____ Age when problem started_____ Problem(s) _____

Other health complaints: Please check if you have major problems with these symptoms:

General
__ fevers
__ chills
__ sweating at night
__ no appetite
__ weight loss
__ weight gain
__ severe fatigue
__ generally ill

Eyes
__ blurred vision
__ double vision
__ eyes pain
__ visual dimming

Ears Nose and Throat
__ hearing loss
__ ringing in ears
__ dizziness/spinning
__ nasal congestion
__ sore throat
__ gum disease
__ dental problems

Respiratory
__ wheezing
__ cough
__ excess sputum
__ coughing blood
__ pain with breathing

Cardiovascular
__ chest pain at rest
__ chest pain with activity
__ breathing problems at rest
__ breathing problems with exertion
__ awaken at night out of breath
__ breathing problems when lying flat
__ leg swelling
__ palpitations
__ lightheadedness
__ passing out
__ leg pain when walking

_____NONE OF THE ABOVE

Gastrointestinal
__ abdominal pain
__ nausea
__ vomiting
__ diarrhea
__ constipation
__ bloody vomit
__ bloody stool
__ black stool
__ jaundice

Genitourinary
__ painful urination
__ urgent need to urinate
__ frequent urination
__ nighttime urination
__ urinary discharge

Musculoskeletal
__ arthritis
__ joint pain
__ muscle pain
__ deformities

Skin/Breast
__ skin rash
__ skin lesions or tumors
__ breast masses
__ breast discharge

Neurological
__ headaches
__ tremors
__ seizure
__ numbness
__ limb weakness
__ difficulty with speech
__ difficulty walking
__ depression
__ anxiety

Please list any DRUG ALLERGIES:

_____

PAST MEDICAL HISTORY (please circle any problems you have or have had)

Abdominal aortic aneurysm
Alcoholism
Alzheimer's disease
Arthritis
Anemia
Anxiety
Asthma
Atrial fibrillation
Benign prostatic hypertrophy
Cancer: _____
Chronic renal failure
Congestive heart failure
Coronary artery disease
Ulcerative colitis
Depression
Other_____

Diabetes
High blood pressure
Gastroesophageal reflux disorder
Hyperlipidemia
Lupus
Myocardial infarction
Obesity
Parkinson's disease
Paroxysmal supraventricular tachycardia
Peptic ulcer disease
Premature ventricular contractions
Prostate carcinoma
Stroke

SURGERIES (please circle any you have had)

Appendectomy
Tonsillectomy
Mastectomy
Breast implantation
Hysterectomy
Prostate
Coronary artery bypass graft surgery
Pacemaker
Mitral valve repair
Mitral valve replacement
Aortic valve replacement
Gallbladder

Stomach removal
Hemorrhoid
Spleen
Rectal polyp
Hernia repair
Cataract surgery
Breast biopsy
Kidney removal
Hip surgery
Skin tumor excision
Any unlisted surgeries_____

Family History

	Age now or at death	Health problems or cause of death
Father:	_____	_____
Mother:	_____	_____
Sibling:	_____	_____
Sibling:	_____	_____
Children:	_____	_____

Social History

Marital status (circle): ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Occupation: _____

Alcohol intake: None____ Drinks per week_____

Caffeine intake: None____ Beverages per day _____

LIST YOUR CURRENT MEDICATIONS & DOSAGES (per day and strength):
(Example:
(Tylenol 500 mg twice a day/morning and evening)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

14.

15.

(additional medications please use reverse side)

Signature_____ Date: _____