American Heart Center, P.C. Patient Registration Form

Welcome to our office! We look forward to providing you with outstanding care.

Name:_____ Social Security#:_____

Date of Birth:_____ Sex: Male or Female (Please circle one)

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Primary Phone #:_____**Home Cell or Work**
(Please circle one)

Secondary Phone #:_____**Home Cell or Work**

Email Address:_____ Primary Care Physician:_____

Patient's Employer Name & Address:_____

Marital Status: Single Married Widowed Divorced Separated (Please circle one)

Emergency Contact's Name:_____Phone #:_____

Whom may we thank for referring you to our practice?:_____

Insurance Information

Primary Insurance Co:_____ Effective Date:_____

ID#:_____ Group#:_____

Subscriber's Name:_____ Subscriber's DOB:_____

Subscriber's SS#:_____ Relationship to Subscriber:_____

Secondary Insurance Co:_____ Effective Date:_____

ID#:_____ Group#:_____

Subscriber Name:_____ Subscriber's DOB:_____

Subscriber's SS#:_____ Relationship to Subscriber:_____

Medicare Lifetime Signature on File: (Please sign below if you have Medicare)
I request that payment of authorized Medicare benefits be made on my behalf to American Heart Center , P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these service payable for related services.

_____ _____
Patient, Parent, or Guardian Signature (if child is under 18 years old) Date

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned, authorize payment of medical benefits to American Heart Center, P.C. for any services furnished to me. I understand that I am financially responsible for any amount not covered by my insurance company. I also authorize you to release to my insurance company any information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits.

_____ _____
Patient, Parent, or Guardian Signature (if child is under 18 years old) Date

Patient Name :_____

Please answer by circling yes or no.

Do you have a Medigap policy?	Yes	No
Do you have Medicaid?	Yes	No
Are you currently employed?	Yes	No
Are you covered under an employer or union policy?	Yes	No
Do you have a spouse/family member covered by a separate insurance policy?	Yes	No
Do you have a secondary insurance policy?	Yes	No
Are you here for treatment for injuries sustained related to a motor vehicle accident?	Yes	No

If yes, please provide:

Insurance Co:_____

Billing Address:_____

Your Claim #:_____ Date of Accident:_____

Your Policy #:_____

Claim Adjuster:_____ Adjuster's #:_____

Are you here for treatment for injuries sustained from a work related injury?	Yes	No

If yes, please provide:

Employer's Name:_____

Employer's Address:_____

Employer's Phone #:_____ Supervisor:_____

Worker's Compensation Insurance Co:_____

Billing Address:_____

Your Claim #:_____ Date of Injury:_____

Claim Adjuster:_____ Adjuster's #:_____

_____ _____

Patient's Signature Date

The following information is used for our physicians to properly asses your cardiac risk factors in order to provide you with optimal care. Please answer the following questions to the best of your ability.

Today's Date:_____

Name:_____ DOB:_____ Current Age:_____

Race:_____ Primary Language:_____

Pharmacy Name & Number:_____

Other physicians presently treating you:_____

Reason for today's visit:_____

Current Medications & Dosages: (Including Medications taken on an as needed basis, OTC, Vitamins)

We kindly ask that you bring an updated medication list with you to each office visit.

_____

_____

Please list any allergies you have to medications, foods, or substances:_____

Are you allergic to iodine, shellfish, IV Contrast, or Latex?_____

Social History:

Occupation:_____ Are you currently under significant stress?_____

If yes, what are your stressors?_____

Do you presently smoke? ( )No ( )Yes Please circle: Cigarettes Cigars Pipe How much per day?_____

If you are a former smoker, when did you quit?_____ Do you exercise regularly?_____

Do you drink alcohol? ( )No ( )Yes What type of alcohol & how often?_____

Do you regularly drink coffee? ( )No ( )Yes Amount consumed daily?_____

Have you ever engaged in recreational drug use?_____ If yes, what type?_____

Females: Are you pregnant, planning a pregnancy, or currently nursing?_____

Please list all previous cardiac surgeries & approx date:_____

Please list any other previous surgeries & approx date:_____

Do you have any metal in your body? (pacemaker, defibrillator, rods, shrapnel, etc.)_____

Immunizations:

If known, please list the year your vaccine was last received.

Influenza:_____ Pneumonia:_____ Tetanus:_____ Zostavax (Shingles):_____

Hepatitis B:_____ Small Pox:_____ Polio:_____ Measles/Mumps/Rubella:_____

Personal Medical History:

Please check all of the following symptoms/conditions that apply to your personal health:

( )Chest Pain/Tightness	( )Kidney Disease	( )Varicose Veins	( )Blood Clots
( )Heart Attack	( )Aneurysm	( )Ulcers	( )Arthritis
( )Shortness of breath	( )Diabetes	( )Skin Disorders	( )Memory Loss
( )High Cholesterol	( )Thyroid Problems	( )Glaucoma/Cataracts	( )TB
( )High Blood Pressure	( )Cancer	( )Asthma/COPD	( )MRSA/Staph Infection
( )Dizzy Spells	( )Stroke	( )Acid Reflux	( )Hepatitis
( )Fainting Spells	( )Scarlet or Rheumatic Fever	( )Blood in Stools	( )HIV/AIDS
( )Palpitations	( )Back Pain/Disorder	( )Swelling/Pain in Legs	( )Other:_____

Please provide a brief explanation for any symptoms or conditions marked above.

_____

_____

_____

Have you ever had:

Please circle any of the following that may apply.

Blood transfusion prior to 1992	Contact with blood/bodily fluid	Shared razor/toothbrush
Engaged in IV drug use	Tattoos	Body piercing

Family Medical History:

		Father:	Mother:	Sibling:	Child:	Grandparent:
Heart Attack:	at what age?	_____	_____	_____	_____	_____
Sudden Cardiac Death:	at what age?	_____	_____	_____	_____	_____
High Blood Pressure:	at what age?	_____	_____	_____	_____	_____
High Cholesterol:	at what age?	_____	_____	_____	_____	_____
Diabetes:	at what age?	_____	_____	_____	_____	_____
Stroke:	at what age?	_____	_____	_____	_____	_____
Cancer:	what type?	_____	_____	_____	_____	_____
Aneurysm:	where?	_____	_____	_____	_____	_____
Blood Clots:	where?	_____	_____	_____	_____	_____

Is there any other information you would like to share with us?

_____

_____

_____

American Heart Center, P.C.

ACKNOWLEDGMENT OF HIPPA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

I, _____, have received a copy of the practice's Notice of HIPPA Privacy.

_____ _____

Signature of Patient (Parent or Guardian, if patient is under 18 years old) Today's Date

Designation of Certain Relatives, Emergency Contacts, Close Friends, Other Caregivers: I agree that the practice may disclose certain health information to a family member, close personal friend, or care giver since such person is involved with my health care or payment relating to my health care. In that case, American Heart Center, P.C., will disclose information that is directly relevant to the person's involvement with my health care of payment to my health care.

My Emergency Contact is: Print Name:_____

Primary Phone Number: _____ Home Cell or Work

Secondary Phone Number: _____ Home Cell or Work

_____ _____

Signature of Patient (Parent or Guardian, if patient is under 18 years old) Today's Date

I WISH TO BE CONTACT IN THE FOLLOWING MANNER [please check all that apply]**:**

Telephone Communication [please check all that apply]:

- **Primary Phone Number: _____** Home Cell or Work
  OK to leave message with detailed information? Yes No
- **Secondary Phone Number: :_____** Home Cell or Work
  OK to leave message with detailed information? Yes No

Written Communication [please check all that apply]:

- **Ok to email?** Yes No **My Email is: _____**
- **Ok to mail to my home address?** Yes No

I designate the following person(s) listed below to correspond and receive my protected health information. I understand that I am not required to list anyone. I also understand that I may request to change this list at any time in writing.

Print Name:_____ Relationship _____

Print Name:_____ Relationship _____

Print Name:_____ Relationship _____

The following persons listed below are not authorized to receive my patient health information.

Print Name:_____ Relationship _____

_____ _____

Signature of Patient (Parent or Guardian, if patient is under 18 years old) Today's Date