CARDIOVASCULAR HEALTH INSTITUTE

Date: _____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES			
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	**ADDRESS**		
CITY, STATE	**ZIP**	**HOME PHONE**	**CELL PHONE**
PATIENT DATE OF BIRTH	**PATIENT SSN**	**SEX** ❑ **Male** ❑ **Female**	**MARITAL STATUS** ❑ **Single** ❑ **Married** ❑ **Other**_____
PATIENT EMPLOYER NAME	**PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)**	**EMPLOYER PHONE**	

INSURANCE INFORMATION		
PRIMARY DOCTOR/FAMILY DOCTOR	**REFFERING DOCTOR**	
IN CASE OF EMERGENCY CONTACT	**RELATIONSHIP**	**PHONE NUMBER**

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	**DATE**

Authorization to release health information to:			
Name(s)	**ADDRESS**		
CITY, STATE	**ZIP**	**HOME PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER** **DATE:**		

Release the following information:
❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

RELEASE OF INFORMATION

I understand that:

- Once "cardiology solutions llc" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**	**EMAIL**
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**	

CARDIOVASCULAR HEALTH INSTITUTE

Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

*** **Preferred Pharmacy:**

Allergies

❑ NONE/No Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Contrast Dye ❑ Latex ❑ Morphine ❑ Penicillin
❑ Wheat
❑ Sulfa Drugs

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Occupation: _____ ☐ Retired ☐ Disabled (reason _____)
☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (__ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed
❑ allergies
❑ anemia
❑ arthritis conditions
❑ asthma
❑ arterial fibrillation
❑ bleeding problems
❑ BPH
❑ CAD coronary artery disease
❑ cancer
❑ cardiac arrest
❑ celiac disease
❑ chest pain
❑ CHF congestive heart failure
❑ chronic fatigue syndrome
❑ depression
❑ diabetes
❑ drug/alcohol abuse
❑ erectile dysfunction
❑ fibromyalgia
❑ Gerd
❑ heart disease
❑ high cholesterol
❑ hyperinsulinemia
❑ hyperlipidemia
❑ hypertension
❑ hypogonadism male
❑ hypothyroidism
❑ infection problems
❑ insomnia
❑ irritable bowel syndrome
❑ kidney problems
❑ menopause
❑ migraines/headaches
❑ neuropathy
❑ onychomycosis
❑ organ injury
❑ osteoporosis
❑ pulmonary embolism/blood clot in legs
❑ seizure disorders
❑ shortness of breath
❑ sinus conditions
❑ stroke
❑ syndrome X
❑ tremors
❑ wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PERSCRIBING DOCTOR