

### PATIENT REGISTRATION

**PLEASE PRINT AND COMPLETE ALL ENTRIES**

<b>PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)</b>		<b>ADDRESS</b>		
<b>CITY, STATE</b>		<b>ZIP</b>	<b>HOME PHONE</b>	<b>CELL PHONE</b>
<b>PATIENT DATE OF BIRTH</b>	<b>PATIENT SSN</b>	<b>SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>MARITAL STATUS</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____
<b>PATIENT EMPLOYER NAME</b>		<b>PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)</b>		<b>EMPLOYER PHONE</b>

#### INSURANCE INFORMATION

<b>PRIMARY DOCTOR/FAMILY DOCTOR</b>		<b>REFERRING DOCTOR</b>		
<b>IN CASE OF EMERGENCY CONTACT</b>		<b>RELATIONSHIP</b>	<b>PHONE NUMBER</b>	

**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.

<b>SIGNATURE (Patient or, if minor Signature of parent or guardian)</b>	<b>DATE</b>
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#### Authorization to release health information to:

<b>Name(s)</b>		<b>ADDRESS</b>		
<b>CITY, STATE</b>		<b>ZIP</b>	<b>HOME PHONE</b>	<b>DAYTIME PHONE</b>
<b>DATES OF SERVICE</b>		<b>AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)</b>		
<b>FROM:</b>	<b>TO:</b>	<input type="checkbox"/> NEVER <b>DATE:</b>		
Release the following information:				
<input type="checkbox"/> All Records <input type="checkbox"/> Chart Notes <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Operative Reports <input type="checkbox"/> 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.

<b>SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE</b>		<b>DATE</b>	<b>EMAIL</b>
<b>IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT</b>		<b>SIGNATURE OF WITNESS (Optional):</b>	

**PATIENT MEDICAL HISTORY**

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

**\*\*\* Preferred Pharmacy:**

**Allergies**

- |  |  |                                     |                                   |                                     |
|--|--|-------------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> NONE/No Known Allergies | <input type="checkbox"/> Adhesive Tape                 | <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Codeine    |
| <input type="checkbox"/> Dairy Products          | <input type="checkbox"/> Iodine/Shellfish/Contrast Dye | <input type="checkbox"/> Latex      | <input type="checkbox"/> Morphine | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Sulfa Drugs             | <input type="checkbox"/> Wheat                         |                                     |                                   |                                     |

**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?

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

**Medications:** List any medications you are currently taking (please include over the counter medications):

**PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE**

MEDICATION	DOSAGE	PERSCRIBING DOCTOR