



Patient Registration Form

Patient's Name (Last) _____ (First) _____ (Middle) _____

Address (NO PO BOX) _____

City _____ State _____ Zip Code _____

Phone Number _____ Work _____ Cell _____

Email Address _____

Date of Birth _____ SS # _____ Sex Male Female

Marital Status Single Married Divorced Widow

Guarantor _____ SS # _____ DOB _____

Address _____ Phone # _____ Work # _____

Referring Physician _____ Primary Care Physician _____

Emergency Contact _____ Phone Number _____

Employment Status Employed Unemployed Self-Employed Retired Part-Time Student Full-Time Student

Employer _____ Phone Number _____

Employer Address _____ City _____ State _____

Primary Insurance _____ Insured SS # _____

Subscribers ID _____ Subscribers Policy # _____

Name of Insured _____ Insured DOB _____

Secondary Insurance _____ Insured SS # _____

Subscribers ID _____ Subscribers Policy # _____

Name of Insured _____ Insured DOB _____

***please provide your insurance card(s) to the front desk at check-in)*

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) Signature

Date



Patient Consent Form

(Please Read and Sign)

I understand complications can occur. By consenting to this exam, I hereby consent to the necessary medical or surgical actions of the physician and/or colleagues, medical/surgical; whomever they choose to consult with to take appropriate actions in regard to this procedure should any complications occur during my visit.

I understand that Centennial Heart Cardiovascular Consultants may include consent at satellite offices under common ownership.

I, the undersigned, authorize Centennial Heart Cardiovascular Consultants to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

Patient Financial Responsibility: I understand my financial responsibility and I guarantee payment for all charges not covered by my insurance, all applied deductibles and co-pays, within 30 days of receiving a statement.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Centennial Heart Cardiovascular Consultants.

I acknowledge that I have been given the Centennial Heart Cardiovascular Consultants Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initial:** _____

May we leave messages on your voice mail/answering machine? Yes No

If yes, which # _____

May we release/discuss your healthcare information with anyone other than you? Yes No

If yes, please list _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or person authorized to consent for the patient)

Date

NEW PATIENT QUESTIONNAIRE

MR # _____ Today's Date _____

Patient Name _____ Date of Birth _____ Age _____

Primary Care Provider _____ Who referred you to us? _____

Preferred Pharmacy? _____ Street _____ City/St _____ Ph/Fax _____

What is your reason for today's visit? _____

Have you had any recent testing (Stress Testing, Ultrasound, Blood work, etc.) at another office? Yes No
Where? _____

Are you currently experiencing any of these symptoms? (check yes or no)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No chills | <input type="checkbox"/> Yes <input type="checkbox"/> No cough | <input type="checkbox"/> Yes <input type="checkbox"/> No palpitations | <input type="checkbox"/> Yes <input type="checkbox"/> No male impotence |
| <input type="checkbox"/> Yes <input type="checkbox"/> No fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No excessive snoring | <input type="checkbox"/> Yes <input type="checkbox"/> No pain in legs/buttocks at rest | <input type="checkbox"/> Yes <input type="checkbox"/> No muscle weakness/pain |
| <input type="checkbox"/> Yes <input type="checkbox"/> No fever | <input type="checkbox"/> Yes <input type="checkbox"/> No vomiting blood | <input type="checkbox"/> Yes <input type="checkbox"/> No pain in legs/buttocks when walking | <input type="checkbox"/> Yes <input type="checkbox"/> No dizziness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No weight gain | <input type="checkbox"/> Yes <input type="checkbox"/> No wheezing | <input type="checkbox"/> Yes <input type="checkbox"/> No abdominal pain | <input type="checkbox"/> Yes <input type="checkbox"/> No seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No weight loss | <input type="checkbox"/> Yes <input type="checkbox"/> No chest pain | <input type="checkbox"/> Yes <input type="checkbox"/> No blood in stool | <input type="checkbox"/> Yes <input type="checkbox"/> No cold or heat intolerance |
| <input type="checkbox"/> Yes <input type="checkbox"/> No vision changes | <input type="checkbox"/> Yes <input type="checkbox"/> No shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No indigestion | <input type="checkbox"/> Yes <input type="checkbox"/> No excessive thirst or urination |
| <input type="checkbox"/> Yes <input type="checkbox"/> No ringing in ears | <input type="checkbox"/> Yes <input type="checkbox"/> No swelling | <input type="checkbox"/> Yes <input type="checkbox"/> No nausea | <input type="checkbox"/> Yes <input type="checkbox"/> No easy bruising |
| <input type="checkbox"/> Yes <input type="checkbox"/> No nose bleeds | <input type="checkbox"/> Yes <input type="checkbox"/> No exercise intolerance | <input type="checkbox"/> Yes <input type="checkbox"/> No vomiting | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No vertigo | <input type="checkbox"/> Yes <input type="checkbox"/> No passing out | <input type="checkbox"/> Yes <input type="checkbox"/> No blood in urine | |

Are you allergic to any medications? Yes No If so, please list: _____

Are you allergic to contrast dye: Yes No Shellfish: Yes No

Have you been treated for any of the following conditions? (check yes or no)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No high blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No high cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No kidney problems | <input type="checkbox"/> Yes <input type="checkbox"/> No tuberculosis (TB) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No heart failure | <input type="checkbox"/> Yes <input type="checkbox"/> No blood clots | <input type="checkbox"/> Yes <input type="checkbox"/> No rheumatic fever | <input type="checkbox"/> Yes <input type="checkbox"/> No cancer |
| <input type="checkbox"/> Yes <input type="checkbox"/> No blockage of the heart | <input type="checkbox"/> Yes <input type="checkbox"/> No stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No hiatal hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No sleep apnea |
| <input type="checkbox"/> Yes <input type="checkbox"/> No blockage of the neck/leg | <input type="checkbox"/> Yes <input type="checkbox"/> No diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No stomach problems | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No abnormal heart rhythm | <input type="checkbox"/> Yes <input type="checkbox"/> No lung disease | <input type="checkbox"/> Yes <input type="checkbox"/> No thyroid problems | |

Please list any other medical condition not listed above: _____

Please list all of the surgeries that you have had: _____

Have you ever had a heart attack? Yes No When? _____

Have you ever had heart surgery? Yes No When? _____

Have you had an arteriogram (dye test) or PTCA/stent/balloon? Yes No When? _____

Have you had surgery for circulation problems in your legs? Yes No When? _____

SOCIAL HISTORY:

Marital Status: Married Single Widowed Divorced

Employment Status: Employed Unemployed Retired Disabled

Occupation: _____

What type of work do/did you do? _____

Do you smoke? Yes No If yes, how many packs per day? _____ For how long? _____

Do you drink alcohol? Yes No If yes, how much? _____

Do you drink caffeine? Yes No If yes, how much? _____

Do you use any recreational drugs? Yes No

Do you exercise? Yes No If yes, what do you do and how often? _____

FAMILY HISTORY:

Are there members of your immediate family with the following conditions:

Heart disease? Yes No Who? _____ Age of first episode _____

Heart surgery? Yes No Who? _____ Age of first episode _____

Irregular heart rhythms? Yes No Who? _____ Age of first episode _____

PLEASE HAVE YOUR MEDICATIONS AVAILABLE FOR THE NURSE.

For Office Use Only

BP _____ HR _____ WT _____ HT _____ BMI _____ CardioSight _____

CC: _____

EKG done? Yes No

Testing prior: _____