CARDIOLOGY CONSULTANTS, PC

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___ J. Bradley Proctor, M.D.
___ Gregory Hamrick, C.R.N.P.
___ Caleb Elmore, C.R.N.P.

PATIENT INFORMATION

DATE: _____ **ACCT. NUMBER:** _____

Patient Name_____
(First) (Middle) (Last)

Date of birth: _____ **Age:** _____ **Marital Status:** **Married/Single**
(Circle)

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Phone Numbers: Home: _____ **Cell:** _____ **Work:** _____

E-mail: _____ **Male or Female** **Social Security No:** _____

Did another physician refer you here? Y / N **Referring physician:** _____

Who is your family physician? _____

Language: English / Spanish / Other **Race:** _____ **Ethnicity: Nonhispanic / Hispanic**
(Circle)

Employed: Y / N / Retired **Employer:** _____ **Phone:** _____

Spouse's Name: _____**Spouse's Employer:** _____ **Phone:** _____

INSURANCE INFORMATION

Primary Insurance Name: _____**Effective date:** _____
Contract Number: _____ **Group Number:** _____
Insured Name: _____**Insured's Date of Birth:** _____
Employer Plan? Y / N **Employer:** _____
Patient's relation to insured party: Self / Spouse / Parent / Child / Other **Male / Female**

Secondary Insurance Name: _____ **Effective date:** _____
Contract Number: _____ **Group Number:** _____
Insured Name: _____ **Insured Date of Birth:** _____
Employer Plan? Y / N **Employer:** _____
Patient's relation to insured party: Self / Spouse / Parent / Child / Other **Male / Female**

PLEASE HAVE YOUR DRIVER'S LICENSE AND ALL INSURANCE CARDS AVAILABLE FOR US TO SCAN. THANK YOU.

What is an alternate contact name and number of a person not living with you?
Name: _____ **Phone:** _____ **Relation:** _____

INSURANCE AUTHORIZATION

I hereby authorize Cardiology Consultants, P.C. to release any medical information needed by my insurance carriers in order to process my claim. I hereby authorize payments direct to Cardiology Consultants, PC. I understand that it is my responsibility to provide correct insurance information to Cardiology Consultants, P.C. I understand that my insurance may not pay the bill and that some of the services may be considered "noncovered" by my insurance contract. I understand that I will be responsible for the balance of my account. In the event of a returned check, I understand that a $25.00 fee will be charged to my account at Cardiology Consultants, P.C.

_____ **Date** _____ _____ **Date**_____
Patient's Signature (Agreement to Pay) **Guarantor's Signature (Agreement to Pay)**

Revised 04/14/15

Patient Name: _____ Date of Birth:_____ Date: _____

Past Medical History

Please check and add details out to the side

Have you ever been told that you had:

- ☐ Anemia
- ☐ Asthma
- ☐ Aneurysm: abdominal ☐ thoracic
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Atrial Flutter
- ☐ Coronary artery disease
- ☐ Cancer
- ☐ Cellulitis
- ☐ Claudication
- ☐ Congestive heart failure
- ☐ Connective Tissue Disease (Lupus,Sardcoidosis,etc)
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ CVA/Stroke
- ☐ Deep Vein Thrombosis
- ☐ Diabetes (insulin or non-insulin dependent)
- ☐ Dialysis
- ☐ Endocarditis
- ☐ Gastrointestinal Bleed
- ☐ Gastroesophageal reflux disease (GERD)
- ☐ Heart block
- ☐ Hypertension
- ☐ Irregular heart rhythm
- ☐ Liver disease
- ☐ Lipid disorder
- ☐ MI (heart attack)
- ☐ Murmur
- ☐ MVP (mitral valve prolapse)
- ☐ PAH (Pulmonary Artery Hypertension)
- ☐ Phlebitis
- ☐ Pleurisy
- ☐ PUD (peptic ulcer disease)
- ☐ Pulmonary Embolism
- ☐ PVD (peripheral vascular disease)
- ☐ Renal Failure ☐ Insufficency
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Seizure Disorder
- ☐ SVT (supraventricular tachycardia)
- ☐ Syncope
- ☐ TB (tuberculosis)
- ☐ Thyroid disorder
- ☐ TIA (transient ischemic attack)
- ☐ Valvular Heart Disease
- ☐ Ventricular Tachycardia

Surgical History

Please check and list date / facility / surgeon

- ☐ Abdominal Surgery _____
- ☐ Amputation: above knee
- ☐ Amputation: below knee
- ☐ Anesthesia Problems
- ☐ Aneurysm Repair
- ☐ Aortic Valve Repair ☐ Replacement
- ☐ Appendectomy
- ☐ Arteriogram ☐ carotid ☐ legs ☐ kidneys
- ☐ Bypass: Aorta-femoral ☐ left ☐ right
- ☐ Bypass: Fem-pop ☐ left ☐ right
- ☐ CABG (Open heart)
- ☐ Congenital heart surgery
- ☐ Endarterectomy ☐ Lt carotid ☐ Rt carotid
- ☐ EPS (Electrophysiology Study)
- ☐ Gallbladder surgery
- ☐ Heart Cath (dye test)
- ☐ ICD (Defibrillator) ☐ ICD : Bi-V
- ☐ Mitral Valve Repair ☐ Replacement
- ☐ Pacemaker
- ☐ PTCA (Angioplasty / stent) heart
- ☐ PTCA (Angioplasty / stent) leg ☐ kidney
- ☐ Stent ☐ Aorta ☐ Carotid ☐ Iliac
- ☐ Surgical Complications
- ☐ Thyroid surgery

Other operations _____

_____

_____

_____

Patient Name: _____ Date: _____

Home Medications

List all medications & dosage you are presently taking and how frequently you take them:

Medication / Dose / Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all known allergies:

_____
_____
_____
_____
_____

Family History

Please check and add any details out to the side

Please circle family member(s) where applicable

☐ Unknown	[father, mother, sibling, grandparent]
☐ Aortic Aneurysm	[father, mother, sibling, grandparent]
☐ Asthma	[father, mother, sibling, grandparent]
☐ Bleeding Disorder	[father, mother, sibling, grandparent]
☐ Cancer _____	[father, mother, sibling, grandparent]
☐ Congestive Heart Failure	[father, mother, sibling, grandparent]
☐ Connective Tissue Disease	[father, mother, sibling, grandparent]
☐ Coronary Artery Disease	[father, mother, sibling, grandparent]
☐ Coronary Heart Disease-male < 55	[father, sibling, grandparent]
☐ Coronary Heart Disease-female < 55	[mother, sibling, grandparent]
☐ CVA or Stroke	[father, mother, sibling, grandparent]
☐ Diabetes	[father, mother, sibling, grandparent]
☐ Hyperlipidemia (cholesterol problems)	[father, mother, sibling, grandparent]
☐ Hypertension	[father, mother, sibling, grandparent]
☐ Marfan's Syndrome	[father, mother, sibling, grandparent]
☐ PAH (Pulmonary Artery Hypertension)	[father, mother, sibling, grandparent]
☐ Peripheral vascular disease	[father, mother, sibling, grandparent]
☐ Prolonged QT	[father, mother, sibling, grandparent]
☐ Renal Disease	[father, mother, sibling, grandparent]
☐ Sudden Cardiac Death	[father, mother, sibling, grandparent]
☐ Thyroid Disease	[father, mother, sibling, grandparent]

Mother living? Yes No Age at death _____ Father living? Yes No
Age at death _____ Number of living brothers & sisters _____ Number of deceased brothers & sisters _____

Social History

Marital Status: Single, Married, Divorced, Widowed

How many children do you have? _____

What is your occupation: _____

Disabled Retired

Smoking History:

Current Smoker: year started _____

Cigarettes: _____ packs per day

Cigars: _____ number per week

Smokeless: _____ amount per day

Counseled to quit or cut down: Yes No

Former smoker: year quit _____

Never smoked:

Passive smoke exposure Yes No

Do you drink alcoholic beverages? Yes No

Types of Alcohol? _____

How many drinks per day? _____

Drug Use? Yes No (If yes circle type below)

Marijuana, cocaine, crack, heroin, illicit prescription
Other _____

Do you drink caffeinated drinks? Yes No

How many per day? _____

Do you drink diet drinks? Yes No

Are you on a special diet? Yes No

Calorie Limited Low Salt
Low Fat Diabetic
High Fiber Low Cholesterol
Other _____

Do you exercise on a regular basis? Yes No
How many times per week? _____
Type of exercise? _____

Do you have a barrier to communication? Yes No
(If yes, circle impairment below)

Non-English Speaking Hearing Impairment
Vision Impairment

High Risk Behavior? Yes No

Comments: _____

Cardiology Consultants

Patient Name: _____ Date of Birth: _____ Date: _____

Review of Systems (please check if you have any of the following)

General

- ☐ Daytime sleepiness
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Cardiovascular

- ☐ Chest pain
- ☐ Fainting
- ☐ Heart racing (palpitations)
- ☐ Swelling in feet/legs (peripheral)

Respiratory

- ☐ Cough
- ☐ Excessive snoring
- ☐ Shortness of breath
- ☐ Wheezing

Neurologic

- ☐ Dizziness (lightheadedness)
- ☐ Morning headaches

Gastro-Intestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody stools
- ☐ Indigestion
- ☐ Dark tarry stools
- ☐ Nausea
- ☐ Vomiting

Genital-Urinary

- ☐ Difficult urination (dysuria)
- ☐ Blood in urine (hematuria)

Musculo-Skeletal

- ☐ Leg pain
- ☐ Muscle cramps

Dermatologic

- ☐ Non-healing ulcer
- ☐ Scar to chest
- ☐ Scar to leg

Ears, Nose, Throat

- ☐ Hoarseness
- ☐ Nosebleed

Psychiatric

- ☐ Anxiety
- ☐ Depression

Allergies

- ☐ Allergic to dye
- ☐ Allergic to iodine
- ☐ Allergic to medications
- ☐ Allergic to shellfish

Form Completed By

Physician Signature

CARDIOLOGY CONSULTANTS, PC
PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Date of Birth: _____ **Social Security No:** XXX-XX- _____

Any physician, staff, employee or representative of Cardiology Consultants, PC, has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number (s)
Name	Relationship	Phone Number (s)
Name	Relationship	Phone Number (s)
Name	Relationship	Phone Number (s)
Name	Relationship	Phone Number (s)
Name	Relationship	Phone Number (s)
Name	Relationship	Phone Number (s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Cardiology Consultants, PC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individual(s).

Patient signature: _____ Date: _____

CARDIOLOGY CONSULTANTS, PC

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Medication History Consent Authorization

By signing below, I hereby authorize Cardiology Consultants, P.C. to obtain my Medication History from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

_____
Date of Authorization

_____ _____
Print Name **Date of Birth**

_____
Signature (Patient/Legal Representative or Parent/Legal Guardian)

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Cardiology Consultants, P.C. may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Pharmacy _____

Location_____