PATUXENT CARDIOLOGY ASSOCIATES

PATIENT REGISTRATION: PLEASE PRINT ALL INFORMATION REQUESTED CLEARLY

NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: (P.O. Box if applicable) _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____

SOCIAL SECURITY #: _____ BIRTH DATE: _____ EMAIL: _____

SEX: MALE / FEMALE [ ] MARRIED [ ] SINGLE [ ] OTHER: _____

RACE: ○ Caucasian ○ Black ○ Asian ○ Other ETHNICITY: ○ Non-Hispanic ○ Hispanic

HOW DID YOU LEARN ABOUT OUR PRACTICE: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

ADDRESS OF PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONACT: _____ RELATIONSHIP: _____

PHONE #: _____ CELL #: _____ WORK #: _____

EMPLOYER: _____ OCCUPATION: _____ WORK #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RESPONSIBLE PARTY FOR PATIENTS BILL: IF SELF MARK HERE { } IF OTHER THAN SELF PLEASE FILL IN:

NAME: _____ { } SPOUSE { } PARENT { } OTHER

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ WORK #: _____ CELL #: _____

PRIMARY INSURANCE CO.: _____

POLICY/MEMBER ID#: _____ GROUP #: _____

INSUREDS NAME: _____ [ ] SELF [ ] SPOUSE [ ] PARENT

SECONDARY INSURANCE CO.: _____

POLICY/MEMBER ID#: _____ GROUP #: _____

INSUREDS NAME: _____ [ ] SELF [ ] SPOUSE [ ] PARENT

(1) Do you have any drug allergies or have you ever had an adverse reaction to any medication?
If so, what? _____

(2) Have you ever responded adversely to medical or dental treatment?

_____

(3) Are you currently under the care of a physician? [ ] YES [ ] NO

For what conditions? _____

(4) (WOMEN) Do you suspect you are or could be pregnant? [ ] YES [ ] NO OR Are you currently nursing? [ ] YES [ ] NO

(5) Is there anything else we should know about your medical history? _____

_____

Please List Medications Below:

Medication	Dosage	How Often?

I certify that the information I have reported above is accurate and true to the best of my knowledge and is only for use in my treatment, billing, & processing of insurance benefits of which I am entitled. I will not hold my doctor or any member of Patuxent Cardiology responsible for any errors or omissions that I have made in the completion of this form. I further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. This authorization may be revoked by myself at any time in writing. I authorize Patuxent Cardiology Associates, LLC., to release and/or send medical information regarding my case to other consulting and/or referring physicians.

I hereby authorize this office to apply for benefits on my behalf for covered services rendered by Patuxent Cardiology Associates, LLC., and their services. I request payment from my insurance company be made to Patuxent Cardiology. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. We will accept assignment for Medicare and other participating insurance companies as paid in full except for the copay and deductible. I understand I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default.

Signature: _____ Date: _____

PATUXENT CARDIOLOGY ASSOCIATES

PATIENTS NAME: _____

PLEASE CIRCLE ALL THAT APPLY

Constitutional:
- o Loss of appetite
- o Sleeplessness
- o Un-explained fever
- o No energy
- o Unplanned weight loss

Respiratory:
- o Short of breath
  - o All the time
  - o With exertion
  - o At night

Do you use home Oxygen?
YES / NO

Neurological:
- o Weakness
- o Numbness
- o Frequent or new headaches
- o Loss of memory
- o Trouble walking
- o Trouble with balance

Eyes:
- o Double vision

Musculoskeletal:
- o Painful joints
- o Painful muscles
- o Neck pain
- o Lower back pain

Cardiovascular:
- o Chest pain
- o Chest tightness
- o Palpitations
- o Sleep sitting up
- o Fainting spells
- o Swelling of feet or ankles
- o Dizzy spells

Nose & Throat:
- o Sinus pain
- o Nasal congestion
- o Trouble swallowing
- o Frequent nose bleeds

Genito-urinary:
- o Trouble urinating
- o Genital discharge
- o Blood in urine
- o Loss of control of urine
- o Recent increased urination

Gastro-intestinal:
- o Abdominal Pain
- o Blood in stool
- o Frequent diarrhea
- o Black stool
- o Frequent constipation
- o Change in bowel
- o Nausea/vomiting

Hematological:
- o Easy bruising
- o Swollen glands
- o Bleed easily

Psychiatric:
- o Recent depression
- o Recent poor sleep
- o Recent poor appetite
- o Crying spells
- o Suicidal thoughts
- o Hearing voices
- o anxiety

Do you need help with any of the following activities?
Dressing (yes / no) Bathing (yes / no) Eating (yes / no) Walking (yes / no) Shopping (yes / no)

Social History: (circle or fill all that apply)

With who do you live? _____ How many children do you have? _____

Do you currently smoke? o **Yes** o **No** Have you ever smoked? o **Yes** o **No** Do you Vape? o **Yes** o **No**

Are you prescribed medical marijuana? o **Yes** o **No** Do you partake in recreational drug use? o **Yes** o **No**

Do you Chew Tobacco? o **Yes** o **No** Have you ever Chewed Tobacco? o **Yes** o **No**

Do you consume alcohol? o **Yes** o **No** If Yes, how much? _____

Past Medical History:

Heart Attack	o **Yes**	o **No**	Stroke	o **Yes**	o **No**	Stents	o **Yes**	o **No**
Coronary Bypass Graft	o **Yes**	o **No**	Diabetes	o **Yes**	o **No**	COPD	o **Yes**	o **No**
High blood pressure	o **Yes**	o **No**	Cancer	o **Yes**	o **No**	CHF	o **Yes**	o **No**
Kidney Disease	o **Yes**	o **No**	CAD	o **Yes**	o **No**	Thyroid Disease	o **Yes**	o **No**
High Cholesterol	o **Yes**	o **No**	Depression	o **Yes**	o **No**	Anxiety	o **Yes**	o **No**
Alcoholism	o **Yes**	o **No**	Type of Cancer: _____					

Past Surgical History:

Cardiac Surgeries & Procedures
- o Cardiac Cath
- o Coronary Artery Bypass
- o Ablation
- o Cardioversion
- o EP Study
- o Heart Valve Repair / Replacement
- o Coronary Angioplasty / Stent
- o ICD / Pacemaker implant
- o Other:_____

If you have had any of the above cardiac surgeries or procedures, please indicate the approximate year and Hospital the procedure was performed._____

Other Surgeries & Procedures:
- o Aneurysm Repair
- o Cholecystectomy
- o Mastectomy
- o Peripheral Vascular
- o Appendectomy
- o Hysterectomy
- o Nephrectomy
- o Carotid Surgery
- o Kidney Stone treatment
- o Tonsillectomy
- o Gastric Bypass
- o Knee Surgery
- o Other:_____

FAMILY HISTORY: (List all Family Members):

○ Family **History Unknown**

Heart Attack	○ Yes	○ No
Stroke	○ Yes	○ No
Coronary Bypass Graft	○ Yes	○ No
Diabetes	○ Yes	○ No
High blood pressure	○ Yes	○ No
Cancer	○ Yes	○ No
Kidney Disease	○ Yes	○ No
Coronary Artery Disease	○ Yes	○ No
Sudden Death	○ Yes	○ No

Family Member: _____
Family Member: _____
Family Member: _____
Family Member: _____
Family Member: _____
Family Member: _____
Family Member: _____
Family Member: _____
Family Member: _____

Father living? ○ Yes ○ No

Mother living ○ Yes ○ No

# of Sisters: _____ # of Sisters alive: _____ # of Sisters deceased: _____

# of Brothers: _____ # of Brothers alive: _____ # of Brother deceased: _____

Pharmacy Preference: _____ Pharmacy #: _____

_____

Signature Date

PATUXENT CARDIOLOGY ASSOCIATES

Authorization for Release of Information to Family Members

Patient Name_____

Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below. I authorize Patuxent Cardiology Associates to release my medical and/or billing information to the following individual(s):

Name: _____

Relation to Patient: _____

Name: _____

Relation to Patient:_____

Name: _____

Relation to Patient:_____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Signature:_____

Date:_____