PINEYWOODS HEART

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NEW PATIENT FORM

_____

NAME LAST, FIRST D.O.B AGE SEX

MAILING ADDRESS: _____

STREET CITY ZIP

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL: _____

PHYSICAL ADDRESS (if different): _____

STREET CITY ZIP

SOCIAL SECURITY NO.: _____ DRIVER'S LICENSE NO./STATE: _____

PRIMARY INSURANCE COMPANY: _____

POLICY NO.: _____ GROUP NO.: _____

PRIMARY HOLDER: _____

NAME D.O.B. SOCIAL SECURITY NO.

SECONDARY INSURANCE COMPANY: _____

POLICY NO.: _____ GROUP NO.: _____

PRIMARY HOLDER: _____

NAME D.O.B. SOCIAL SECURITY NO.

NAME OF PERSON LEGALLY RESPONSIBLE: _____

PREFERRED PHARMACY: _____

REFERRING DOCTOR: _____

SIGNIFICANT OTHER/PARENT INFORMATION

NAME: _____ D.O.B.: _____ PHONE: _____

EMPLOYED: _____ WORK PHONE: _____

WHAT IS YOUR MAIN REASON FOR SEEING A CARDIOLOGIST? _____

DO YOU HAVE ANY PREVIOUS CARDIAC PROBLEMS AND HOW WERE THEY TREATED (including angioplasty or heart surgery)?

_____

PREVIOUS HEART TESTS: Stress Test _____ Echocardiogram _____ Holter Monitor_____ Cardiac Catheterization _____

HAVE YOU HAD ANY OF THE FOLLOWING:

High blood pressure _____ If yes, how long? _____ years Treated? _____ Which meds? _____

Diabetes _____ If yes, how long? _____ years Treated? _____ Which meds? _____

	YES/NO	WHEN		YES/NO	WHEN
Heart Attack	_____	_____	Heart Murmur	_____	_____
Chest Pain (Angina)	_____	_____	Mitral Valve Prolapse or leak	_____	_____
Shortness of breath	_____	_____	Rheumatic Fever	_____	_____
Cough/Recent respiratory infection	_____	_____	Heart Valve Infection	_____	_____
Chest injury/trauma	_____	_____	Mini-Stroke or stroke	_____	_____
Congestive heart failure	_____	_____	Claudication (leg pain)	_____	_____
Leg Swelling	_____	_____	Deep vein thrombosis	_____	_____
Nausea/vomiting/diarrhea	_____	_____	Bleeding problems/anemia	_____	_____
Dizziness/Fainting	_____	_____	Asthma/Chronic bronchitis	_____	_____
Heart rhythm problems	_____	_____	Palpitations	_____	_____

PAST SURGERIES: _____

ALLERGIES TO MEDIATION: _____ ALLERGY TO IODINE/CONTRAST DYE: _____

MEDICATIONS

NAME	DOSE	TIMES/DAY	NAME	DOSE	TIMES/DAY
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

FAMILY HISTORY:

Heart Attack _____ Stroke _____ Hypertension _____ Diabetes ____

Mother living? YES NO If yes, any present illness _____ If no, age of death _____ died of _____

Father living? YES NO If yes, any present illness _____ If no, age of death _____ died of _____

Siblings _____ Age _____ Health _____ Age _____ Health _____
Age _____ Health _____ Age _____ Health _____

Any deceased? Age _____ Cause _____
Age _____ Cause _____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO HERBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THE CLAIM.

PATIENT SIGNATURE: _____ DATE: _____
RELATIONSHIP to patient (if applicable): _____