PATIENT REGISTRATION

☐ MR. ☐ MRS. ☐ MS _____

LAST NAME | FIRST NAME | MIDDLE

SOCIAL SECURITY NUMBER | AGE | RACE | ETHNICITY | DATE OF BIRTH

STREET ADDRESS

CITY | STATE | ZIP CODE | HOME PHONE NUMBER

EMPLOYER'S NAME | EMPLOYER'S ADDRESS | BUSINESS PHONE NUMBER

EMAIL ADDRESS

PATIENT PORTAL | CELL PHONE | PREFERRED METHOD OF COMMUNICATION

SPOUSE / SIGNIFICANT OTHER'S NAME | SPOUSE / SIGNIFICANT OTHER'S DATE OF BIRTH

PRIMARY CARE PHYSICIAN | REFERRED BY

PHARMACY NAME & CITY | PHARMACY PHONE

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

LAST NAME | FIRST NAME | MIDDLE

SOCIAL SECURITY NUMBER | AGE | DATE OF BIRTH

STREET ADDRESS

CITY | STATE | ZIP CODE | HOME PHONE NUMBER

EMPLOYER'S NAME | EMPLOYER'S ADDRESS | BUSINESS PHONE NUMBER

INSURANCE INFORMATION (Copies of insurance & pharmacy cards will be made)

INSURANCE COMPANY	POLICY OR CONTRACT #	GROUP NUMBER	INSURED NAME

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I, the undersigned, authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or with any public agency and its agents to determine benefits for services provided and/or benefits for related services.

NOTICE OF PRIVACY PRACTICES: I, the undersigned, acknowledge that I have been offered and/or received a copy of Birmingham Heart Clinic's "Notice of Privacy Policies".

PRIOR CONSENT TO CONTACT: I, the undersigned, give Birmingham Heart Clinic, its employees and/or agents, "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance, payment or appointment reminders.

ASSIGNMENT OF BENEFITS: I, the undersigned, hereby authorize payment or benefits be made directly to Birmingham Heart Clinic, P.C. for services provided to me by Birmingham Heart Clinic, P.C. **I understand that I am financially responsible for charges not covered by this assignment.** I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event my account (Patient Balance) becomes delinquent (in excess of 90 days old), I accept and agree to pay the cost of professional collection services (30%), including attorney fees and/or court costs if such are necessary.

_____ X _____

DATE

Cardiovascular Patient Data

Today's Date: _____

Name: _____ Date of Birth: _____

Age: _____ Sex: **M** **F** Height: _____ Weight: _____

Primary Care Doctor/Provider(s): _____

Why are you here to see the cardiologist?

_____

Referred by: _____

Please check off any of the following that apply to you:

- ☐ Heart attack
- ☐ Angina
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Murmur
- ☐ History of Rheumatic Fever
- ☐ Abnormal Heart Rhythm (arrhythmia)
- ☐ Palpitations or Irregular Heartbeats
- ☐ Fainting
- ☐ Enlarged Heart
- ☐ Chest Pain, Pressure or Heaviness
- ☐ Arm or Shoulder Pain or Heaviness
- ☐ Neck, Jaw or Throat Discomfort
- ☐ Shortness of Breath
- ☐ Dizziness or Light-headedness
- ☐ Swollen Calves or Ankles
- ☐ Heart Failure
- ☐ Blue Lips or Fingernails
- ☐ Leg Pain While Walking
- ☐ Aneurysm
- ☐ Sleep Apnea
- ☐ Kidney Failure/Dialysis/ Chronic Kidney Disease
- ☐ COPD/Asthma/Lung Disease
- ☐ Vein Insufficency
- ☐ Blood Clot
- ☐ Congenital Heart Defect
- ☐ Valve Disorder
- ☐ HIV
- ☐ Hepatitis C

If any apply, When? Month & Year _____

_____

_____

Please specify any other illnesses or medical conditions you have now or have had in the past: _____

_____

_____

Cardiovascular Patient Data

Full Name: _____ Age: _____ Date: _____

CURRENT MEDICATIONS:

Medication Name	Mgs	Number you take each time	Number of times you take per day	If recently stopped, last date taken

ALLERGIES:

Are you allergic to any drugs? ☐ Yes ☐ No Have you ever had a reaction to x-ray dye such as given for kidney x-rays ☐ Yes ☐ No

_____

_____

_____

PLEASE list all **PREVIOUS SURGERIES:** _____

_____

_____

_____

Please list prior **CARDIAC/VALVE & VEIN PROCEDURES/TESTING** you have had done outside of our office, physician & date/year:

_____

_____

HABITS: Caffeine use: Amount_____ How often?_____ Other Substance Use _____

Tobacco/Smoking (check one):

☐ Never Smoked ☐ Currently Smoking # of Packs Per Day _____ ☐ Vape ☐ Oral Tobacco

☐ Used to Smoke When did you quit?_____

Alcohol (check one): ☐ Yes _____ drinks/day_____ drinks/month ☐ No

Exercise Type: _____ How often?_____

WOMEN: Are you pregnant? ☐ Yes ☐ No Do you take birth control? ☐ Yes ☐ No Menopause? ☐ Yes ☐ No

Do you take Estrogen replacement? ☐ Yes ☐ No Breast size: _____

SOCIAL HISTORY:

Education Completed: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Present Occupation: _____

FAMILY HISTORY:

	Living		Age	Heart	High Blood Problem	High Pressure	Stroke Cholesterol	Diabetes	Cancer
Father:	Yes	No	_____	☐	☐	☐	☐	☐	☐
Mother:	Yes	No	_____	☐	☐	☐	☐	☐	☐
Brother:	Yes	No	_____	☐	☐	☐	☐	☐	☐
Sister:	Yes	No	_____	☐	☐	☐	☐	☐	☐

AUTHORIZATION FOR PAYMENT:

I hereby authorize payment directly to the provider of services, and I understand that I am responsible for medical charges, co-pays and/or deductibles not covered by my insurance company.
I am aware that I, not my insurance company, am responsible for the entire account. I understand that my insurance is a contract only between my insurance company and myself and not with ***Birmingham Heart Clinic, P.C.***

AUTHORIZATION TO OBTAIN MEDICATION HISTORY:

I hereby authorize ***Birmingham Heart Clinic, P.C.*** to obtain my medical history from my pharmacy, health plans, and other healthcare providers. By signing this consent form I am giving ***Birmingham Heart Clinic, P.C.*** permission to collect and the pharmacy and other health insurer permission to disclose information about my medications have been filled at any pharmacy or covered by any health insurance plan.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the physicians and/or staff of ***Birmingham Heart Clinic, P.C.*** to release medical information such as office notes and/or test results to myself, person(s) listed below and/or other physicians assisting with my medical care until notified otherwise.

AUTHORIZATION TO RELEASE TEST RESULTS:

I hereby authorize the physicians and/or staff of ***Birmingham Heart Clinic, P.C.*** to discuss my medical condition and/or test results:

Please check all that apply: ☐ only to myself

☐ leave results on answering machine

☐ release only to the following person(s):

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

* _____ _____

Patient's Name or Responsible Party *(please print)* D/O/B

* _____ _____

Patient's Signature or Responsible Party Date

_____

Witness

(This authorization is valid unless notified in writing by the patient.)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Section A: Must be completed for all authorizations.

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

PATIENT NAME: _____

DATE OF BIRTH: _____ **SSN:** _____

Please identify those persons/organizations authorized to receive your information:

_____

Please provide a specific description of your information to be used or disclosed (identification, including date(s):

_____

Please provide a statement describing each purpose for the requested use or disclosure of your information:

_____

Section B: Must by completed for all authorizations

The patient or patient's representative must read and initial the following statements:

a) I understand that Birmingham Heart Clinic, P.C. will not condition my treatment (and, if applicable, payment for my health care, my enrollment in a health plan, or eligibility for benefits) on whether I provide authorization for the requested use or disclosure-except in limited circumstances (e.g. if the treatment is research-related or the treatment is necessary for the purpose of creating protected health information for disclosure to a third party, such as physical examinations for school, camp, and employment purposes).

Initials _____

b) I understand that I may revoke this authorization at any time by notifying Birmingham Heart Clinic, P.C. in writing; however, such revocation does not affect any actions taken by Birmingham Heart Clinic, P.C. before Birmingham Heart Clinic, P.C. received my written revocation.

Initials: _____

c) I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulation or other applicable state or federal laws.

Initials: _____

d) I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

Initials: _____

e) I understand that this authorization will expire on _____ (identify date) or _____ (identify expiration event).

Initials: _____

f) I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization.

Initials: _____

* _____ _____

Signature of Individual or Personal Representative of Individual Date

Printed Name of Personal Representative: _____

Relationship of Personal Representative to Individual: _____

You may refuse to sign this authorization