



PATIENT REGISTRATION

NOTE: Most fields are required. If field does not apply please enter N/A

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

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 PRACTICE: 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 by email and 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. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

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 any/all collection agency fees, (33%), including attorney fees and/or court costs if necessary

DATE: _____ **SIGNATURE:** _____

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 doctor?

Referred by: _____

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

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

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: _____

Why are you here to see the doctor? _____

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

SOCIAL HISTORY:

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

Present Occupation: _____

FAMILY HISTORY check all that apply:

	Living	Age at Death	Heart Event	High Blood Pressure	Stroke/High Cholesterol	Diabetes	Cancer
Father:	Yes No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother:	Yes No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother:	Yes No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister:	Yes No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If any apply, MORE DETAIL: _____

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 be 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: _____