
THANK YOU FOR CHOOSING CARDIAC ASSOCIATES, P.C.
FOR YOUR CARDIAC CARE.

- Please **arrive 15 to 20 minutes prior to your appointment time** to allow sufficient time for the registration/check in process. Please have the **following forms completed, your insurance card, any co-pay that is needed, and a photo identification card** with you when you arrive to the office. Please fill out everything that you can that is not boxed in.

- Also, please have any recent blood work and/or EKG you have had done in any other office with you when you arrive to your appointment. You can also have your doctor's office fax the information to us ahead of time (301-924-0186 ROCKVILLE FAX, 301-634-4801 OLNEY FAX, 240-449-1150 GERMANTOWN FAX, 301-924-0180 LAUREL FAX). Please bring in a list of medications (prescribed and over the counter) that you are currently taking including strength and dosage information. Instead of a list, you may bring the bottles.

- If you have an insurance policy that requires a referral to see a specialist, please either bring the referral with you or have your doctor fax it to us ahead of time (FAX NUMBERS LISTED ABOVE). If you are unsure if you need a referral, please call your insurance company. The phone number is usually listed on the back of your insurance card.

- If you are having any type of testing done such as an **ECHOCARDIOGRAM, STRESS TEST** (NUCLEAR, EXERCISE, or STRESS ECHO), **DOPPLER, or any other type of testing**, it is essential that you bring a written order (this is different from a referral) with specific instructions on what type of testing is needed. Without this specific order, we may not be able to perform the test.

- Please **do not mail or fax** this packet back to us. Please fill out to the best of your ability and hand carry it with to your appointment time and date. Please give this packet to the person at the front desk when you check in minus this cover sheet. If you have any questions or concerns about your appointment, or need to cancel or reschedule, please feel free to contact the scheduling department at **301-548-7603**. Any other questions or concerns, (such as but not limited to prescription refills, the doctors nurse, billing or the medical records department), please call the main line (301-670-3000 FOR ROCKVILLE, 240-449-1100 FOR GERMANTOWN, 301-634-4800 FOR OLNEY, & 301-924-0466 OR 410-724-0026 FOR LAUREL) and choose the prompt for the appropriate department.

We appreciate your cooperation and look forward to seeing you.

Thank you.

Cardiac Associates, P.C.

15225 Shady Grove Rd. Suite 201 Rockville, MD 20850 301-670-3000 (F) 240-632-0653	19735 Germantown Rd Suite 190 Germantown, MD 20874 240-449-1100 (F) 240-449-1150	7350 Van Dusen Rd. Suite 410 Laurel, MD 20707 301-924-0166 (F) 301-924-0180	18109 Prince Phillip Dr Suite 125 Olney Md 20832 301-634-4800 (F) 301-634-4801
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PATIENT NAME : _____ , _____
(LAST NAME) (SUFFIX) (FIRST NAME) (MIDDLE)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (____) _____ - _____ Cell #: (____) _____ - _____

Date of Birth _____ SS#: _____

Occupation: _____ Male _____ Female

Work #: (____) _____ - _____ ext.: _____

Patient Employer: _____

Employer Address: _____

Spouse: _____ Phone #: (____) _____ - _____

Emergency Contact: _____ Phone: (____) _____ - _____

Referring DR.: _____ Phone:(____) _____ - _____ Fax: (____) _____ - _____

Primary Care DR. : _____ Phone:(____) _____ - _____ Fax: (____) _____ - _____

Insurance info:

Primary Insurance: _____ Policy Holder Name: _____

Policy Holder D.O.B.: _____ Policy Holder SS#: _____ - _____ - _____

Ins. Address: _____ Phone: (____) _____ - _____

Ins ID: _____ Group #: _____

Secondary Insurance: _____ Policy holder name: _____

Policy Holder D.O.B.: _____ Policy Holder SS#: _____ - _____ - _____

Ins. Address: _____ Phone: (____) _____ - _____

Ins. ID #: _____ Group #: _____

Patient Signature: _____ Today's Date: _____

*****PLEASE PRINT CLEARLY*****
***** PLEASE HAVE YOUR INSURANCE CARD AND PICTURE ID AVAILABLE WHEN CHECKING IN*****

Cardiac Associates, P.C

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI).
CARDIAC ASSOCIATES WILL NOT USE THIS INFORMATION FOR MARKETING RESEARCH OR SOLICITATION
OF ANY KIND. YOUR PROTECTED INFORMATION (PHI) IS FOR THE SOLE PURPOSE OF TREATING YOU,
THE PATIENT.**

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Name: _____

Address: _____

Phone: Home: _____ **Cell:** _____

Work _____ **Fax:** _____

Date Of birth: _____ **SS #:** _____

I AUTHORIZE CARDIAC ASSOCIATES TO RELEASE MY MEDICAL RECORDS, LAB AND ECHO REPORTS, AND/OR BILLING RECORDS, FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO) ONLY. I UNDERSTAND CARDIAC ASSOCIATES WILL NOT RELEASE ANY OTHER INFORMATION WITHOUT FIRST SEEKING AUTHORIZATION FROM ME.

IF YOU DO NOT WANT YOUR TEST RESULTS, BILLING INFORMATION OR ANY OTHER CORRESPONDENCE FROM CARDIAC ASSOCIATES TO BE SENT TO YOUR HOME ADDRESS, WHERE WOULD YOU LIKE IT SENT?

I AUTHORIZE CARDIAC ASSOCIATES TO: (PLEASE CHECK ALL APPROPRIATE RESPONSES):

- _____ Send my billing info to my home address
_____ Be contacted by phone to confirm appointments
_____ FAX my test results or other info to my fax number: _____
_____ Leave a voicemail message on my answering machine confirming appointments.
_____ Leave message at the above phone number to give updates on medication and/or treatment
_____ To discuss TPO with the following designated person or persons: _____

I UNDERSTAND THAT THIS AUTHORIZATION WILL BE EFFECTIVE FOR ONE YEAR FROM THE DATE SIGNED AND THAT AT ANY TIME I HAVE THE RIGHT TO REVOKE ANY AUTHORIZATION.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO OBTAIN TREATMENT, RECEIVE PAYMENT OR ELIGIBILITY FOR BENEFITS UNLESS ALLOWED BY LAW.

Signature of Patient or Rep.: _____ **Date:** _____

If Rep., Relation to Patient: _____

CARDIAC ASSOCIATES, P.C.

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to providing you with high quality care and to forming a relationship with you that is built on trust. We understand that information about you is private and we are committed to protecting this information. We protect your privacy and confidentiality rights by creating and putting into practice policies and procedures that allow access to your personal information only for legitimate reasons.

This notice describes how your health information may be used and disclosed by us, your rights with regards to your health information, and our duties to protect such information. It applies to all records of your care that we maintain. Whether this information is stored in writing, on computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

This section describes how we use and disclose your health information. Below, we have listed the types of uses and disclosures that we may make. Any use or disclosure that is not listed below will only be made with your written authorization.

Without Your Authorization.

Your health information may be used and disclosed by us for the following purposes without your legal permission. However, prior to making such disclosure that is not listed below will only be made with your written authorization.

Treatment, Payment and Business Purpose: We use and disclose your health information to enable us to provide treatment to you, obtain payment for your care, and manage and administer our practice. For instance, we may use and disclose your health information to your insurer, HMO, or other third party payer to obtain for the services that we provide you. As another example, in consulting with a specialist regarding your health care treatment, we use and disclose your information. As a further illustration, we may use and disclose your health information to review the adequacy and quality of the care that you receive. As another example of managing our practice, we may use and disclose your information to create de-identified information to enable us to study our treatment patterns and the care that we provide.

Individuals Involved in Your Care or Payment or Notifications: We may disclose your information to your family members or friends who are involved in your care or who assist you in paying for your care. If we need to notify family and/or friends of your medical condition and/or location, we may also disclose your information. This notification may be via a disaster relief effort, such as the American Red Cross.

CARDIAC ASSOCIATES, P.C.

ACCT. # _____

ACKNOWLEDGMENT OF PRIVACY NOTICE RECEIPT

I have been provided a copy of the Notice of Privacy practices for Cardiac Associates with an effective date of April 14th, 2003.

Signature of Patient or representative

Date

If representative, relationship to patient: _____

DATE: _____

CARDIAC ASSOCIATES

ACCT. #: _____

NEW PATIENT FORM

Patient Name: _____ D.O.B. _____ Age: _____

Referring Doctor/Hospital: _____ / _____

HT. _____

Other Doctors you see: _____

WT. _____

Pharmacy Phone # / Name: (_____) _____ - _____ / _____

Reason for visit, CHIEF COMPLAINT(S) (CC): _____

Past Medical History

(list MOST RECENT surgeries / hospitalization / major medical problems)

1. _____
2. _____
3. _____
4. _____
5. _____

If more space is needed, please use back of this form.

Family History

Mother: Age _____

Alive?: Yes (list any chronic illnesses) _____

No (specify cause of death) _____

Father: Age: _____

Alive?: Yes (list any chronic illnesses) _____

No (specify cause of death) _____

Siblings: Age: _____

Alive?: Yes (list any chronic illnesses) _____

No (specify cause of death) _____

Siblings: Age: _____

Alive?: Yes (list any chronic illnesses) _____

No (specify cause of death) _____

Children: Age: _____

Alive?: Yes (list any chronic illnesses) _____

No (specify cause of death) _____

If more space is needed, use the reverse side of this form.

Social History

Occupation: _____

Marital Status: Single/Married/Divorced/Widowed

Smoking: Yes No How much?: _____ Duration? _____

Recreational Drug use: Yes No

What Kind: _____ How Often: _____

Alcohol Use: How many drinks consumed per day on average? _____

Do you exercise? Yes / No. How often?: _____

Coffee / Tea / Soda, How Often?: _____

If more space is needed, please use the back of this form.

HISTORY OF PRESENT ILLNESS (HPI)

OFFICE USE ONLY

CC: _____

- * LOCATION
- * QUALITY / DESCRIPTION = MILD / MOD. / SEVERE / VARIABLE
- * SEVERITY = MILD / MOD. / SEVERE / VARIABLE
- * DURATION = (WHEN DID IT START / DURATION)
- * TIMING
- * CONTEXT
- * MODIFYING FACTORS = (MAKES SX'S WORSE/BETTER)
- * ASSOCIATED SIGNS AND SYMPTOMS = (SOB, SWEATS, LIGHTEADEDNESS)

(Include CV risk factors)

RISKS:

DM____, HBP____, CIG____, CHOL____, FHx____

CARDIAC PMH:

- PRIOR: MI (HEART ATTACK)
- CABG (BYPASS SURGERY)
- ANGIOPLASTY
- PACER/DEFIBRILLATOR
- VEIN PROCEDURES
- LOWER EXT. ANGIO/SURGERY
- CAROTID STENT / SURGERY
- LOSS OF CONSCIOUSNESS / DIZZINESS
- PALPITATIONS / ARRHYTHMIAS
- HEART MURMURS OR VALVE SURGERY
- SOB W / W/O EXERTION
- CHOL. ABNORMALITY
- CLAUDICATION (LEG PAIN WITH WALKING)
- EDEMA / LEG ULCERATION / HEAVINESS / VARICOSITIES

M.D. Initials _____, Date: _____ **PG. 1**

PATIENT'S NAME: _____

ACCOUNT #: _____

ALLERGIES TO MEDICATIONS

REACTION:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

- _____
- _____
- _____
- _____

IF MORE SPACE IS NEEDED, PLEASE USE THE BACK OF THIS PAGE.

CURRENT MEDICATION NAMES AND DOSE:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____

- 8. _____
- 9. _____
- 10. _____

ALTERNATIVE MEDICATIONS (THERAPY)

- 1. _____
- 2. _____
- 3. _____

IF MORE SPACE IS NEEDED, PLEASE USE THE BACK OF THIS PAGE.

Do you have any of the following? (circle):

Constitutional - fever, chills, unexplained weight change (loss/gain).

Eyes - blurred or double vision, loss of vision, discharge.

Ears - discharge, ringing, loss of hearing.

Throat - hoarseness, trouble swallowing.

Nose - bleeding, sinus problems.

G.I. - vomiting, nausea, blood in stool, diarrhea, constipation, indigestion (heartburn), GI bleed, GERD (reflux), hiatal hernia.

Neuro - unusual headaches, seizures, loss of consciousness, weakness of extremities, stroke (CVA)

Endo - excessive thirst, excessive urinating, heat or cold intolerance, diabetes, thyroid disease.

Skin - rash, ulcer, lesion(s).

Heme - easy bruising, anemia, swollen glands, blood cancer

Allergy/Immuno - seasonal allergies

Psych - anxiety, depression.

Respiratory - cough, sputum production, blood in sputum, shortness of breath, asthma, wheezing.

MALE: Prostate abnormalities, Testicular disease.

FEMALE: Pregnancy, breast / ovarian, BCP (contraception)

Extremities: edema, leg pain w/activity, cramping, fractures

Musculo skeletal: muscle disease, arthritis, lumbar / cervical disorder.