



CAPITAL HEART ASSOCIATES

Patient Information: **PLEASE FILL OUT COMPLETELY**

DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____

SSN: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

How did you hear about us? Referring Doctor Yellow Pages Internet Search Word of Mouth Other: _____

Home Address: _____ City: _____ County: _____ State: _____ Zip: _____

Preferred Mailing Address: _____ City: _____ County: _____ State: _____ Zip: _____

(We do not accept a PO box for a home address)

Sex: Male Female Referring Physician: _____

Employer: _____

Person to Contact in an Emergency: _____

Relationship to Patient: _____ Phone Number: _____

INSURANCE

Primary Insurance: _____

Name of Policy Holder: _____ Birthdate: _____

Employer of Policy Holder: _____ Policy Holder's SSN: _____

Employer's Phone: _____ Insurance Co's Phone: _____

Member #: _____ Group#: _____

Secondary Insurance: _____

Name of Policy Holder: _____ Birthdate: _____

Employer of Policy Holder: _____ Policy Holder's SSN: _____

Employer's Phone: _____ Insurance Co's Phone: _____

Member #: _____ Group#: _____

Tertiary Insurance: _____

Name of Policy Holder: _____ Birthdate: _____

Employer of Policy Holder: _____ Policy Holder's SSN: _____

Employer's Phone: _____ Insurance Co's Phone: _____

Member #: _____ Group#: _____

I request Capital Heart to file my insurance and authorize payment to be made directly to Capital Heart Associates for services rendered. I authorize medical information to be released to the insurance carrier and/or to any requesting physician. I authorize Capital Heart and its assistants to administer medical treatment.

Signature: _____ Date: _____



Capital Heart Associates, P.A.

Financial Policy

Please read and sign below

Thank you for choosing us as your provider of cardiology care. Our physicians and staff look forward to serving you. This financial policy explains your responsibility for insurance and payment services.

We will gladly file your insurance as a courtesy to you unless you request otherwise. Your co-payment, co-insurance, deductible and/or payment for non-covered services is required at the time services are received. Full payment is required if we are not contracted with your insurance plan or if you are not covered by health insurance.

We accept cash, checks and Visa/Mastercard as payment for your bill.

This bill is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company.

Thank you for your understanding and cooperation regarding our financial policy. Please let our staff know if you have any questions.

Patient Signature: _____

Date: _____

Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Chart #: _____

CAPITAL HEART ASSOCIATES, P.A.

COMPLIANCE PROGRAM

Patient Consent Form

By signing this form, you are granting consent to Capital Heart to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our web site or contacting our organization at 919-881-0160.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

By signing this form, you are also acknowledging a copy of Capital Heart's Notice of Health Information Privacy Practices has been provided to you.

Signature: _____

Date: _____



CAPITAL HEART ASSOCIATES

Authorization for Release of Information

Name _____ DOB _____

Chart # _____

Capital Heart Associates is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Leave a message to on my answering machine/voice mail Yes No

Leave a message to remind me of future appointments Yes No

Speak with a family member in my home about my care Yes No
Please list family members _____

Speak with a family member calling the office concerning my care Yes No
Please list family members _____

Speak to family members concerning financial matters Yes No
Please list family members _____

I understand that 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 as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date _____



Medical History Questionnaire

Name: _____ Age: _____ Sex: _____ Race: _____

Problem to be evaluated: _____

Referring Physician: _____

Personal Information

Date of Birth: ___/___/_____ Birthplace: _____ Marital Status: _____

Occupation: _____ Status: Employed [] Retired [] Disabled []

If disabled, for what reason? _____

Past Medical History

Hospitalizations and surgical procedures (continue on back if necessary)

	Hospital & City	Reason	Doctor	Year
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Childhood and Adult Diseases: (check any you have had)

Asthma [] Pneumonia [] Tuberculosis [] Diphtheria [] Syphilis [] Kidney Failure []
Bronchitis [] Emphysema [] Hepatitis [] Diabetes [] Hypertension [] High Cholesterol []

Drug Allergies: _____

Lifestyle

Describe Appetite: _____ Recent weight loss/gain? _____

Amount Per Day: Coffee _____ Tea _____ Soft Drinks _____ Alcohol _____

Smoker: Yes/No If yes, how often: _____ How many years? _____

If no, did you ever? Yes/No How often: _____ How many years? _____
When did you quit? _____

Do you have a history of illicit drug use/abuse? Yes/No What drug(s)? _____
How many years? _____ When did you quit? _____

Patient Signature: _____ **Date:** _____ **MRN:** _____

Family History

Parents	Living?	Age	Health Problems	If deceased, age & cause of death
Father	Yes/No			
Mother	Yes/No			
Siblings				
Male/Female	Yes/No			
Male/Female	Yes/No			
Male/Female	Yes/No			
Children				
Male/Female	Yes/No			
Male/Female	Yes/No			
Male/Female	Yes/No			

Constitutional	Yes	No	Psychosocial	Yes	No	GU	Yes	No
Fever			Depression			Difficulty urinating		
Night Sweats			Trouble Sleeping			Painful urination		
Weakness			Fatigue			Incontinence (leaking)		
Weight Change			Other			Postmenopausal		
Other			Hemat/Lymphat			Other		
Endocrine			Bruise Easily			Neurological		
Thyroid Disorder			Anemia			Headache		
Blood Sugar Problems			Swollen Glands			Dizziness/fainting		
Excessive Sweating			Other			Seizures/convulsions		
Eyes			Allergic/Immune			Numbness in hands/feet		
Glaucoma			Frequent infections			Other		
Cataracts			Throat/face swelling			Musculoskeletal		
Vision Loss			Other			Difficulty walking		
Other			GI			Joint aches/stiffness		
ENT			Heartburn/Indigestion			Painful legs/feet		
Hearing Loss			Abdominal Pain			Back pain		
Dental Problems			Diarrhea/constipation			Other		
Hoarseness			Nausea/Vomiting			Cardiology		
Nose Bleeds			Other			High blood pressure		
Other			Skin/Breast			Heart Murmur		
Respiratory			Color Changes			Rapid heartbeat		
Asthma/Bronchitis			Changes in Moles			Chest pain		
Shortness of Breath			Itching/Scaling			Ankle swelling		
Coughing Up Blood			Breast lump or pain			Leg cramps w/exertion		
Other			Nipple discharge			Other		
			Other					
Reviewed by: (MD)	Date:		Reviewed by: (MD)	Date:		Reviewed by: (MD)	Date:	

Do you have a living will? Yes/No If yes, have you provided us with a notarized copy? Yes/No

For Office Use Only: Copy of Living Will Requested? _____

Patient Signature: _____ **Date:** _____ **MRN:** _____