NSC Cardiology - NEW PATIENT VISIT FORM

(Complete if you have not been seen in over 2 years or are coming to this office for the first time)

Name _____ DOB_____ Age_____

EMAIL _____ Referring Dr _____

Why are you here? Any specific questions for the doctor?

_____

_____

CARDIAC HISTORY:

Any recent heart tests? **If yes, please notify the staff to request copies of the reports**
□ Echo (cardiac ultrasound) □ Stress test □ Nuclear stress test □ Heart Cath
□others_____

Do you;			
Have High blood pressure	yes	no	# of yrs_____
Have High cholesterol	yes	no	# of yrs_____
Have Diabetes	yes	no	# of yrs_____
Smoke	yes	no	# of yrs quit when? _____
Drink alcohol	yes	no	# of yrs amt/week?_____
Exercise at least 3x/week	yes	no	what activity?_____
Have previous heart attack	yes	no	when? _____
Have Previous Stroke	yes	no	when? _____
Have previous heart surgery	yes	no	when? _____
Have previous vascular surgery	yes	no	when? _____
Get chest pains/pressure	yes	no	describe_____
Get dizzy or faint	yes	no	describe_____
Get racing heart/skip beats	yes	no	describe_____
Get shortness of breath	yes	no	describe_____
Get leg swelling	yes	no	describe_____
Have a heart murmur?	Yes	no	describe_____

Current medication list (include herbs/supplements and doses)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current allergy list

_____ _____
_____ _____
_____ _____

Shellfish allergy yes no IV dye allergy yes no

PAST MEDICAL HISTORY:

List all surgeries and year.

_____ _____
_____ _____
_____ _____

List all other hospitalizations and year.

_____ _____
_____ _____
_____ _____

Any other ongoing medical problems?

_____

FAMILY HISTORY:

Any family History of heart disease?
Who?
Relation……
Relation……
Relation……

Condition……
Condition……
Condition……

Mothers age_____
Fathers age_____
Siblings? Yes No

If deceased, cause of death_____
If deceased, cause of death_____
Any health Issues?_____

PSYCHO-SOCIAL HISTORY:

Where were you born?_____ Your Ethnicity_____

Are you? Single married divorced widowed common law partner

Are you? employed unemployed disabled retired student stay at home

Where do or did you work?_____

Describe your current or past job_____

_____

_____

Do you have children? Yes No Ages_____

Are you? under any unusual stress? Yes No Please describe below?

_____

DATE _____ SIGNATURE _____

NSC CARDIOLOGY - REVIEW OF SYSTEMS

(to be filled out if not done in the past 3 months)

NAME_____ **NO CHANGE SINCE LAST VISIT** ☐

PLEASE INDICATE BELOW ONLY IF ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional

Poor general health lately ..... yes
Recent weight loss ..... yes
Fever/ chills ..... yes
Fatigue ..... yes

Eyes and vision

Eye disease or injury..... yes
Wear glasses or contact lenses ..... yes
Blurred or double vision ..... yes
Glaucoma ..... yes

Ears, nose, throat

Hearing loss ..... yes
Ringing in the ears ..... yes
Sinus problems ..... yes
Nose bleeds ..... yes
Bleeding gums ..... yes
Sore throat or voice change..... yes

Genitourinary

Frequent urination..... yes
Burning or painful urination ..... yes
Blood in urine ..... yes
Sexual difficulty/pain ..... yes
Irregular periods (female) ..... yes
Erectile dysfunction (male) ..... yes

Respiratory

Frequent coughing ..... yes
Spitting up blood ..... yes
Shortness of breath ..... yes
Asthma or wheezing..... yes

Gastrointestinal /Extremities

Loss of appetite ..... yes
Constipation ..... yes
Nausea or vomiting ..... yes
Frequent diarrhea ..... yes
Blood in stool ..... yes
Leg cramps/pain ..... yes
Restless legs ..... yes
Leg ulcers/redness ..... yes

Musculoskeletal

Joint pain ..... yes
Joint stiffness or swelling ..... yes
Weakness of muscles/joints ..... yes
Muscle pain or cramps ..... yes
Back pain ..... yes
Difficulty in walking ..... yes

Skin and breasts

Rash or itching ..... yes
Change in skin color ..... yes
Varicose veins ..... yes
Breast pain ..... yes

Neurological

Frequent or recurrent headaches ..... yes
Lightheaded or dizzy ..... yes
Convulsions or tingling sensations ..... yes
Tremors ..... yes
Strokes / TIA ..... yes
Head injury..... yes

Psychiatric

Memory loss or confusion ..... yes
Nervousness/ anxiety ..... yes
Depression ..... yes
Sleep problems ..... yes
Snoring/apnea ..... yes

Endocrine

Glandular or hormone problem ..... yes
Thyroid disease ..... yes
Diabetes ..... yes
Excessive thirst or urination ..... yes
Heat or cold intolerance ..... yes

Hematologic/ Lymphatic

Slow to heal after cuts ..... yes
Easily bruise or bleed ..... yes
Anemia ..... yes
Phlebitis ..... yes
Transfusion ..... yes
Swollen glands ..... yes

ANY OTHER PROBLEMS:

_____

Date: _____ **Signature** _____

North Atlanta Heart & Vascular Center PC

Bhaskar Reddy, M.D.● Jigishu Dhabuwala, M.D ● Don Rowe M.D. ● Narendra Singh, M.D.

PATIENT PROFILE

YOUR NAME: _____Doctor you are seeing:_____

PATIENT INFORMATION

Email :_____

Address:_____

_____

_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

[ ] Male [ ] Female

Date of Birth:_____

Social Security #:_____

[ ] Married [ ] Single [ ] Divorced

Spouse's Name:_____

Referring Physician:_____

Physician Phone #:_____

Primary Physician :_____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Unemployed

Employer:_____

Phone:_____

PHARMACY INFORMATION

Pharmacy Name:_____

Pharmacy #:_____

GUARANTOR (Individual signing this form)

[ ] Same as Patient [ ] Other

Name:_____

Address:_____

_____

_____

GUARANTOR PHONE

Home #:_____

Work #:_____

EMERGENCY CONTACT & PHONE #:

_____

_____

PRIMARY INSURANCE

***Secondary Insurance: Please Provide Information to Front Desk**

Policy Holder's Name:_____

Policy Holder's Phone #:_____

Insurance Co:_____

Insurance Co Address:_____

_____

Relationship to Patient:_____

Policy Holder's SSN:_____

Insurance ID #:_____

Policy Group:_____

Policy Holder's DOB:_____

I consent to have messages regarding test results and appointment reminders left on a voicemail or text message: (Initial)

_____Voicemail/Home #:_____

_____Voicemail/Text/Cell #:_____

_____Voicemail/Business #:_____

I do not consent to messages regarding my test results or appointment reminders on any voicemail or text:_____(Initial)

I voluntarily give consent for my medical treatment or my child's medical treatment to North Atlanta Heart & Vascular Center, P.C. I fully understand that payment is required at the time of service and should my claims be filed to my insurance company, any unpaid balance is my responsibility. When necessary, I further authorize the release of medical records to my insurance company. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician.

_____ _____

Signature Date

North Atlanta Heart & Vascular Center, P.C.

Bhaskar Reddy, M.D.● Jigishu Dhabuwala, M.D ● Don Rowe M.D. ● Narendra Singh, M.D.

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one medication to those who received another, for the same condition. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave North Atlanta Heart & Vascular. We will always ask for your specific permission if the researcher will have access to your name or other information that reveals who you are, or will be involved in your care at North Atlanta Heart & Vascular.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please list to whom we may release your medical records/information.

Name/Relationship:_____

Name/Relationship:_____

Name/Relationship:_____

I, the undersigned, have read the above and authorize North Atlanta Heart & Vascular to disclose such information as herein contained. This office is released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that information disclosed to this authorization may be subject to re-disclosure by the recipient and no longer be protected.

Patient Name:_____ Signature:_____

Relationship to Patient if signing for :_____ Date:_____

North Atlanta Heart & Vascular Center, P.C.

FINANCIAL POLICY

We are all aware of the crisis to healthcare financing nationwide. Quality, personalized medical services may sometimes be expensive and we are working hard to contain costs on your behalf. There is much misunderstanding regarding the role of insurance and other "Third Party Payors" in the process. The following is an attempt to explain our policies in this regard:

1. Services are provided to patients, not to insurance companies. Private practice medicine is Fee-For-Service and implies a contract between patient and provider.
2. Insurance contracts are between companies and beneficiaries (patients) for reimbursement of certain covered expenses.
3. In cases where we do have contracts with managed care providers we will comply with their regulations. In other words, we will be filing your claims with the appropriate carriers and collecting your copay at the time of services.
4. Patients covered under HMO or PPO are responsible for their copay at the time of service. They are also responsible for any portion of charges designated by the insurance company.
5. In order for our business office to file your insurance correctly, you must give the receptionist a copy of your most current insurance card along with your referral number.
6. If your HMO policy requires you to have a referral number, you are responsible to provide the number at time of services.
7. Patients electing to be seen out of network will be responsible for payment at time of services.
8. Patients covered under Medicaid must present current card and copay when applicable.
9. Recipients of medical care are expected to pay for those services whether covered by insurance or not. Insurance coverage is determined by your contract with the company.
10. For certain services (i.e. Procedures, Hospitalizations) we will assist you by filing a claim on your behalf to your insurance company. Bills not paid by insurance remain the responsibility of the patient.
11. In situations of severe financial hardship, this office will consider making special arrangements on a case-by-case basis. Please discuss this with our office manager immediately if you feel it applies to you.
12. We are all here to serve. If you have remaining questions, out staff is ready to help find the answers.

I hereby understand the financial policy of this office.

_____

Print Name

_____ _____

Signature Date

North Atlanta Heart & Vascular Center, P.C.

Bhaskar Reddy, M.D.● Jigishu Dhabuwala, M.D ● Don Rowe M.D. ● Narendra Singh, M.D.
1400 Northside Forsyth Drive Suite 380, Cumming, GA 30041
Phone: 770-887-3255 FAX: 770-887-4177

REQUEST FOR RELEASE OF MEDICAL RECORDS

(This form to be used if we need to get records from a previous physician or previous hospital stay)

Only complete bottom portion of this form

TO:

_____

_____

_____

I hereby request that all my medical records be released to North Atlanta Heart & Vascular Center, P.C. as soon as possible.

Please Print

Patient Name:_____ **Date:**_____

DOB:_____ **SSN:**_____

Address:_____

_____

_____

Patient Signature:_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

North Atlanta Heart & Vascular Center, P.C.

Bhaskar Reddy, M.D.● Jigishu Dhabuwala, M.D ● Don Rowe M.D. ● Narendra Singh, M.D.

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Phone: 770-887-3255, FAX: 770-887-4177.

ACKNOWLEDGEMENT FORM

I have reviewed the Notice of Privacy Practices and have been presented an opportunity to ask questions:

NAME: _____ Date of Birth:_____

Signature_____ Date:_____