CARDIAC CENTER OF SAN ANTONIO

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OF SAN ANTONIO

REGISTRATION FORM

Last Name: _____ First Name: _____ Sex: _____ Preferred Name (if different from legal): _____ SSN: _____ Date of Birth: _____ Marital Status: _____ Address:

City:

State: _____ ZIP Code:

Home Phone: _____ Mobile Phone: _____ Work Phone: _____ Preferred Contact Method: _____ Email Address:

Occupation: _____ Employer:

Employer Phone:

How did you hear about us?

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Member ID/Policy Number:	
Group:	
Name of policy holder:	
Policy holder date of birth:	
Relationship to patient:	
Claims email address:	

Preferred Lab: Quest LabCorp

IN CASE OF EMERGENCY

Name of local friend/relative (not living at same address): _____

Relationship to Patient: _____ Phone: _____ Alt: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand that a charge of $25.00 will be added to my account if I do not show up for a scheduled appointment or fail to give a minimum 24 hour cancellation notice. I understand that if I miss consecutively 3 scheduled appointments that I can be dismissed from the practice. I also authorize CARDIAC CENTER OF SAN ANTONIO or insurance company to release any information required to process my claims

Patient/Guardian Signature: _____ Date: _____

Primary Care Physician (PCP): _____

CARDIAC CENTER OF SAN ANTONIO

PAST MEDICAL HISTORY

Please indicate each of your medical problems by marking the appropriate box:

High Blood Pressure (Hypertension)	Asthma	Please list any other medi cal problems:
Heart Disease	Pulmonary Disease	
Diabetes	Renal Disease/Renal Stent	
Stroke (Year:_____)	Anemia	
Cancer	Elevated Cholesterol	
Thyroid Disease	Glaucoma	
Heart Attack	Stent(s)	
Coronary Artery Disease	Arrhythmias ie Afib	
Substance Dependency	GERD	
Peripheral Vascular Disease	Valvular Disease	
Mental Illness	Rheumatology	
Do you exercise? Yes / No How often: ()		
Have you ever been tested positive for COVID-19: Yes / No		

SOCIAL HISTORY:

Do you smoke? Yes / No
If so, how many a day? _____ Number of years:_____ Year Quit: _____
Do you drink alcohol? Yes / No
If so, how many drinks per week? _____
Do you Vape? Yes / No

FAMILY HISTORY:

If any blood relative has suffered from the following conditions, please check the box and list which relative. (Father, Mother, Grandparents, Sibling, Children)

Heart Disease (Relative: _____)	Asthma (Relative: _____)
Diabetes (Relative: _____)	Emphysema/Lung Disease (Relative: _____)
Thyroid (Relative: _____)	Cancer (Relative: _____)
Stroke (Relative: _____)	Glaucoma (Relative: _____)
High Blood Pressure (Relative: _____)	Mental Health (Relative: _____)
Substance (Relative: _____)	

Surgery/Hospitalizations

Please list any surgeries or hospitalizations (including the year). If you have not had any, please write N/A.

Are you under the care of another doctor for any medical problem? _____

If so, whom and for what medical problem? _____

Year of Last: Tetanus Shot _____ Flu Shot _____ Pneumonia Vaccine _____

Procedures:

EKG (Date: _____)	Bone Density Study (Date: _____)
Colonoscopy (Date: _____)	Cholesterol (normal Y/N) (Date: _____)
Stress Test (Date: _____)	Glucose Test (normal Y/N) (Date: _____)

Females Only: Please list the date of your last mammogram and/or pap smear and the results.

Mammogram (Date: _____)	PAP Smear: (Date: _____)
Result(s): Normal / Abnormal	Result(s): Normal / Abnormal
Note: _____	Note: _____

ALLERGY HISTORY

Have you ever had an allergic reaction to any medication? Yes / No
If yes, please list medication and the reaction:

CURRENT MEDICATIONS		
Please list any medications (prescription and nonprescription) you are currently taking, including vitamins and aspirin. Please use separate sheet if necessary.		
Medication	**Dosage**	**Number taken daily**

Pharmacy

Name of Pharmacy: _____

Phone Number: _____ Fax Number: _____

Address: _____ City: _____

State: _____ ZIP Code: _____

Patient Email Address: _____

Patient/Guardian Signature: _____ Date: _____

Review of Systems			
Have you experienced any of the following symptoms? Please mark yes or no. If yes please provide a brief explanation			
System	**Yes**	**No**	**Explanation**
Cardiovascular			
Chest Pain or Angina			
Irregular heart rhythm			
Swelling of the feet, ankles, or hands			
Constitutional			
Good general health lately			
Recent weight changes			
Extreme Fatigue			
Frequent nausea and /or vomiting			
Difficulty sleeping			
Hematology/Lymphatic			
Leg muscle stiffness or pain			
Weakness of leg muscles			
Difficulty in walking			
Neurological			
Headaches			
Numbness or tingling sensation			
Weakness or paralysis			
Convulsions or seizures			
Loss or blurring of vision			
Blackouts or dizziness			
Memory loss or confusion			
Other neurological problems			
Respiratory			
Breathing problems/shortness of breath			

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ SSN # (optional):

_____ INFORMATION REQUEST

FROM:

Name of Facility / Doctor: _____

Phone Number: _____ Fax Number: _____ City:

_____ Address: _____State:

_____ ZIP Code: _____

Patient Email Address: _____

REQUESTOR OF INFORMATION:

CARDIAC CENTER OF SAN ANTONIO

Phone: (201) 746-5533
Fax: (201) 676-2878

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STAT

INFORMATION REQUESTED:

DESCRIPTION	DATE(S)	DESCRIPTION	DATE(S)
Physician Progress Notes X-Ray Reports		Operative Documentation Laboratory Reports EKG(s)	

PURPOSE OF DISCLOSURE: Continuing care with another physician/hospital Personal Copy

Other (specify): AUTHORIZATION: I understand that:

- This authorization will remain in effect for 365 days
- I may revoke this authorization at any time in writing but if I do, it will not affect any actions taken prior to receiving the revocation
- I may refuse to sign this authorization and that it is strictly voluntary
- If the requestor or receiver is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations and may be re-disclosed
- If I do not sign this form, my health care and the payment for my health care will not be affected
- I understand that I may see and obtain a copy of the information described on this form for a reasonable copy fee, if I ask for it
- I will receive a copy of this form after I sign it

I acknowledge the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

Patient/Guardian/Representative Signature: _____ Date: _____

Patient/Guardian/Representative Printed Name: _____ Date: _____

Witness Signature: _____

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

Federal civil rights laws and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, together protect your fundamental rights of nondiscrimination and health information privacy. Civil Rights help to protect you from unfair treatment or discrimination, because of your race, color, national origin, disability, age, sex (gender), or religion. Federal laws also provide conscience protections for health care providers.
The Privacy Rule protects the privacy of your health information it says who can look at and receive your health information, and also gives you specific rights over that information. In addition, the Patient Safety Act and Rule establish a voluntary reporting system to enhance the data available to assess and resolve patient safety and health care quality issues and provides confidentiality protections for patient safety concerns.

Patient Signature: _____ Date: _____

The following individuals listed below are approved to release medical information to:

Name	Relationship to Patient
Person 1:	
Person 2:	

Cancellation/No Show Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a twenty five dollar ($25) fee this will not be covered by your insurance company.

Prescription Refills:

Please allow 48 to 72 hours to fully process medication refill requests. In order to submit a request, please contact your pharmacy and have them send in a "Medication Refill Request" to our office and it will be handled accordingly.
In some cases, the providers will request to see you for an appointment before filling the prescription(s) for various reasons. In this situation, you will be contacted by a staff member to set up an appointment to meet with the provider.

By signing below, I acknowledge the above information and understand office policies.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Pharmacy Name: _____ Phone: _____ Address: _____

PERMISSION TO TREAT

By signing below, you agree that the information provided above is accurate and up to date. You also agree to allow CARDIAC CENTER OF SAN ANTONIO permission to treat you for this visit.

Signature: _____ Date: _____/_____/_____