

Coastal Cardiology, PA Patient Registration

Cardiologist: _____

Primary Physician: _____

Patient Information

Account #	SS#	Gender:	Age:	D.O.B:
First Name:	Middle Init:	Last Name:		Marital Status:
Address:		Home Phone: Check the box of the Primary Phone Number <input type="checkbox"/>		
City, State & Zip:		Work Phone: <input type="checkbox"/>		
Email:		Cell Phone: <input type="checkbox"/>		
Race/Ethnicity: Black Hispanic White Other:		Primary Language:		
Employer:				

Responsible Party Self (information same as above)

Relationship to Patient:	Date of Birth:
First Name: Initial:	Last Name:
Address:	Home Phone:
City, State & Zip:	Work Phone:
Social Security #	Cell Phone:

Insurance Information

Primary Insurance	Subscriber:	DOB:
Address:	Policy ID:	Group:
City, State & Zip:		
Plan Phone #:	Patient Relationship to Subscriber:	
Secondary Insurance	Subscriber:	DOB:
Address:	Policy ID:	Group:
City, State & Zip:		
Plan Phone #	Patient Relationship to Subscriber:	

Parent/Spouse/Legal Guardian:	Emergency Contact:
Address (if different)	Address (if different):
Relationship to Patient:	Relationship to Patient:
Home Phone: Other Phone:	Home Phone: Other Phone:

Medical Authorizations & Release of Information

I hereby authorize Coastal Cardiology, PA to furnish the insured's insurance company all information which said insurance may request my present illness or injury. I hereby assign to the doctors all money which I am entitled for medical and/or surgical expenses relative to the services performed. I understand that I am financially responsible to said doctors for all charges. I hereby authorize Coastal Cardiology, PA to provide such medical services including surgery. If necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue to be in full force and effect until revoked in writing by me.

→ _____
Signature

Date

OVER

Coastal Cardiology Medical History

Name _____ Date _____

DOB _____ Age _____

Referring Physician _____

Reason for Visit _____

Height _____ Weight _____ P _____ R _____ B/P _____

Have you ever had any of the following?

Cancer	Yes	No	Stroke	Yes	No
Heart problems	Yes	No	Eye disease	Yes	No
Weight loss	Yes	No	Nervous Disorder	Yes	No
Speech/Hearing problems	Yes	No	Asthma/Emphysema	Yes	No
Anemia	Yes	No	Tuberculosis	Yes	No
Seizures	Yes	No	Night Sweats	Yes	No
Infectious Diseases	Yes	No	Coughing blood	Yes	No
Arthritis	Yes	No	Difficulty swallowing	Yes	No
Kidney problems	Yes	No	Foot or leg ulcers	Yes	No
Are you pregnant?	Yes	No	Poor circulation	Yes	No
Other problems?	Yes	No	Bleeding Problems	Yes	No

Do you have any of the following?

Recent weight loss	Yes	No	Leg pain with walking	Yes	No
Chills	Yes	No	Wheezing	Yes	No
Night Sweats	Yes	No	Cough	Yes	No
Generalized weakness	Yes	No	Bloody cough	Yes	No
Blurry vision	Yes	No	Constipation	Yes	No
Double vision	Yes	No	Diarrhea	Yes	No
Hearing loss	Yes	No	Black/tarry stools	Yes	No
Vertigo	Yes	No	Bloody stools	Yes	No
Lightheadedness	Yes	No	Painful urination	Yes	No
Dizziness	Yes	No	Incontinence	Yes	No
Nose bleeds	Yes	No	Bloody urine	Yes	No
Sore throat	Yes	No	Rashes	Yes	No
Hoarse voice	Yes	No	Itches	Yes	No
Chest pressure or pain	Yes	No	Passing out	Yes	No
Skipping heart	Yes	No	One sided weakness	Yes	No
Shortness of breath	Yes	No	Numbness	Yes	No
Short of breath lying flat	Yes	No	Tingling	Yes	No
Wake up breathless	Yes	No	Excessive urination	Yes	No
Swelling of ankles	Yes	No	Excessive thirst	Yes	No

Social History

Do you smoke? Yes No Former If Yes, how much? _____ When did you quit? _____

Do you use any illicit drugs? No Yes Occasionally

Do you drink alcohol? No Rarely Socially Quit Frequently, _____ drinks a day

Do you drink coffee? No Yes _____ cups per day

Do you drink tea? No Yes _____ cups per day

What type of work do you do? _____

Interests: _____

Do you use any aids such as a walker, cane, wheelchair, hearing aid, etc.?

Do you have any language or learning barriers we need to know about?

Marital status: Married Single Widow Divorced In a relationship

Children: none son(s) daughter(s)

Ages: _____

Exercise: None Regular Occasionally 3x a week or more

Type of exercise: _____

Describe your daily eating habits: _____

Family History

Please mark all that apply.

There is no family history of heart disease or vascular disease.

Father: Alive Deceased Age deceased: _____

Known Conditions: High Cholesterol High Blood Pressure Coronary Artery Disease
 Coronary Artery Bypass Surgery Heart Attack Stroke Other _____

Mother: Alive Deceased Age deceased: _____

Known Conditions: High Cholesterol High Blood Pressure Coronary Artery Disease
 Coronary Artery Bypass Surgery Heart Attack Stroke Other _____

Brother: Alive Deceased Age deceased: _____
Known Conditions: High Cholesterol High Blood Pressure Coronary Artery Disease
 Coronary Artery Bypass Surgery Heart Attack Stroke Other _____

Sister: Alive Deceased Age deceased: _____
Known Conditions: High Cholesterol High Blood Pressure Coronary Artery Disease
 Coronary Artery Bypass Surgery Heart Attack Stroke Other _____

If you have chest pain please answer the following:

Character: Sharp Dull Burning Tightening Other

Duration: less than 10 seconds 10 seconds to 1 minute 1 minute to 15 minutes
 15 minutes to 60 minutes greater than 60 minutes

Provoked by: eating large meals exertion stress or anxiety
 lying flat pressing on the chest wall other

Relieved by: rest walking around taking nitroglycerin eating
 taking antacids rubbing on chest wall burping other

Associated symptoms: (things that occur at the same time you experience chest pain)

shortness of breath palpitations sweatiness nausea
 burping weakness passing out jaw pain arm pain

Risk factors: Circle all that apply

Diabetes Elevated Cholesterol High Blood Pressure Family History of Heart Disease

Miscellaneous

Have you seen a cardiologist previously? yes no
If yes, who? _____ When? _____

Have you ever had heart surgery? yes no
If yes, who? _____ When? _____

Have you ever had a heart catheterization? yes no
If yes, who? _____ When? _____

Have you ever been told you have a heart murmur? yes no
If yes, who? _____ When? _____

