Welcome to City Cardiology Associates

Ihsan Ul Haque, MD, FACC Tariq Saleem, MD, FACC
James D. Maloney, MD, FACC

Patient Registration

NAME: ____

ADDRESS: ____

CITY, STATE, ZIP: ____

TELEPHONE #: ____________________ **CELL #:** ____________________

EMAIL: ____________________ **PATIENT PORTAL ENABLED** ____________

PREFERRED METHOD OF CONTACT: {CIRCLE} HOME TELEPHONE, CELL, EMAIL, EMERGENCY CONTACT

PRIMARY PROVIDER: ____

REFERRING PROVIDER: ____

OTHER SPECIALIST: ____________________ **SPECIALTY:** ____________________

DATE OF BIRTH: ____________________ **GENDER: M F T MARRIED/ SINGLE**

SOCIAL SECURITY # ____

YOUR EMPLOYER: ____________________ **WORK #:** ____________

NAME OF EMERGENCY CONTACT: ____

THEIR TELEPHONE: ____________________ **RELATIONSHIP:** ____________________

DO YOU HAVE A LIVING WILL? Y / N. IF YES, HAVE YOU SUPPLIED A COPY TO CCA? Y / N

DO YOU HAVE A POWER OF ATTORNEY? Y / N.

IF YES, PLEASE PROVIDE NAME AND PHONE: ____

____

RACE: BLACK HISPANIC WHITE OTHER:

LANGUAGES SPOKEN: ____________________ **DO YOU REQUIRE A TRANSLATOR? Y N**

ETHNICITY: NON-HISPANIC HISPANIC OTHER

I also understand, I am financially responsible for any balance, co-pay, and deductible remaining after my bills have been submitted to my medical insurance. If I am uninsured, I am responsible for the balance in it's entirety at the time of service.

SIGNATURE ____________________ **DATE** ____________

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PAST CARDIAC PROCEDURES

WHEN WAS YOUR LAST:

STRESS TEST ? ____________________ **WHERE?** ____________________

ECHOCARDIOGRAM? ____________________ **WHERE?** ____________________

STRESS/ECHO? ____________________ **WHERE ?** ____________________

PACEMAKER / ICD INSERTION? ____________________ **WHERE?** ____________________

CARDIOVERSION ? ____________________ **WHERE?** ____________________

CARDIAC STENT? ____________________ **WHERE?** ____________________

BYPASS? **SINGLE / DOUBLE / TRIPLE / QUADRUPLE /** ____________ **WHERE?** ____________________

CARDIAC CATHETERIZATION? ____________________ **WHERE?** ____________________

ABLATION ? ____________________ **WHERE?** ____________________

Medical History

PLEASE MARK EACH CONDITION THAT APPLIES TO YOU, OR WITHIN YOUR IMMEDIATE FAMILY	YOU	MOTHER'S SIDE ☐ UNKNOWN	FATHER'S SIDE ☐ UNKNOWN
ARRHYTHMIAS (PALPATIONS, AF)			
CONGENITAL HEART DISEASE			
CHEST PAINS/ANGINA			
CONGESTIVE HEART FAILURE			
DEPRESSION/DEPRESSED MOODS			
MI, HEART ATTACK			
HIGH CHOLESTEROL			
HYPERTENSION			
RHEUMATIC FEVER			
SCARLET FEVER			
STROKE / TIA			
COPD			
DIABETES			
ENDOCRINE DISEASES			
RENAL DISEASE			
GOUT			
PERIPHERAL VASCULAR DISEASE			
GASTROINTESTINAL DISORDERS			
LIVER DISEASES			
ARTHRITIS			
GENITAL URINARY DISORDERS			
EPILEPSY			
VENERAL DISEASE			
SEXUAL DYSFUNCION			
OTHER NOT LISTED			

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SURGICAL PROCEDURE HISTORY

LIST ANY OTHER SURGERIES YOU HAVE HAD: (EXAMPLE: APPENDECTOMY, JOINT REPLACEMENTS, ETC)
PROCEDURE: ______________________________ WHERE ____________________________________ YEAR ___________________
PROCEDURE: ______________________________ WHERE ____________________________________ YEAR ___________________
PROCEDURE: ______________________________ WHERE ____________________________________ YEAR ___________________

HOSPITALIZATION HISTORY

LIST ANY HOSPITALIZATIONS, (EXAMPLE: PNEUMONIA, ACCIDENTS, CHEST PAINS, ETC)
WHY: ____________________________________ WHERE ____________________________________ YEAR ___________________
WHY: ____________________________________ WHERE ____________________________________ YEAR ___________________
WHY: ____________________________________ WHERE ____________________________________ YEAR ___________________

FAMILY STATUS

SONS: HOW MANY ALIVE? ________ HOW MANY DECEASED? ___________ CAUSES _______________________________
DAUGHTERS: HOW MANY ALIVE? ____________ HOW MANY DECEASED? ____________ CAUSES ___________________
☐ CHECK HERE IF ADOPTED, AND SKIP TO SURGICAL PROCEDURE HISTORY
IS YOUR FATHER ALIVE? Y /N AGE AT DEATH _________ CAUSE OF DEATH _____________________________________
IS YOUR MOTHER ALIVE? Y /N AGE AT DEATH _________ CAUSE OF DEATH _____________________________________
SISTERS: HOW MANY ALIVE? ____________ HOW MANY DECEASED? ____________ CAUSES _______________________
BROTHERS: HOW MANY ALIVE? ____________ HOW MANY DECEASED? ____________ CAUSES _____________________

SOCIAL HISTORY AND RISK FACTORS

DO YOU CURRENTLY SMOKE: Y /N HOW MANY PACKS DAILY? _________ INTERESTED IN STOPPING? Y /N
DO YOU CURRENTLY USE ILLEGAL DRUGS? Y /N
DO YOU HAVE AN EXERCISE ROUTINE? Y /N DAILY HOURS: ______ WEEKLY HOURS: _______________
CAFFEINE: Y /N 1-2 CUPS DAILY? ___________ 3 OR MORE CUPS DAILY? ______ 12 OZ OR MORE ________
DO YOU FOLLOW A DIET PLAN? Y /N IF SO, WHAT IS THE PLAN ____
DO YOU DRINK ALCOHOL: Y /N DAILY? Y /N WEEKENDS? Y /N SPECIAL OCCASIONS? Y / N
SEXUALLY ACTIVE? Y / N
TRAVEL OUTSIDE US? Y / N IF SO, WHERE? ____
ARE YOU IN CONTACT WITH BODILY FLUID? Y / N

SCREENINGS & SPECIAL TESTING

LADIES-WHEN WAS YOUR LAST TETNUS DONE? _____________________ WHERE? ___________________________________
WHEN WAS YOUR LAST PNEUMOCOCCAL DONE? _______________ __WHERE? ___________________________________
MEN-WHEN WAS YOUR LAST FLU VACCINE DONE? ________________ WHERE? _________________________________
WHEN WAS YOUR LAST MAMOGRAM DONE? ______________________ WHERE ? _________________________________
WHEN WAS YOUR LAST HEMOCCULT ? ___________________________WHERE?___________________________________
WHEN WAS YOUR LAST PPD SHOT? ______________________________ WHERE? ________________________________
WHEN WAS YOUR LAST COLONOSCOPY ? _________________________ WHERE?_______________________________
WHEN WAS YOUR LAST BONE DENSITY TEST? ______________________ WHERE? ______________________________
IF YOU ARE DIABETIC- WHEN WAS YOUR LAST HBA1C LAB TEST? _________________ WHERE? _______________________
YOUR LAST EYE EXAM? ________________________ WHERE? ____
DIFFICULTY FALLING ASLEEP? Y /N DAYTIME DROWSINESS? Y /N DIFFICULTY STAYING ASLEEP Y /N SNORING Y /N

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Medications and Pharmacies

Name ____ ***DOB*** _________________________

Local Pharmacy Name: ________________________ **Telephone #** ________________________

Address: ____

Mail Order Name: _____________________**Telephone #**___________________________________

**** Allergies:** ____

***** *If you already have a list*, we can copy it in place of the below information .**

Medication Name	Strength Mg, mcg, units etc	Directions How often taken?	Who prescribed it for you?

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Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to evaluation and treatment, the use or disclosure of my protected health information by City Cardiology Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, obtain medical history from external sources, or to conduct health care operations at City Cardiology Associates. I understand that diagnosis or treatment of me by the physicians at City Cardiology Associates may be conditioned upon my consent as evidenced by my signature on the document.

This document also serves as my authorization to release my protected health information/medical records to City Cardiology Associates, to be used and/or disclosed to carry out treatment, payment and/or health care operations until such time that this authorization is revoked in writing.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed, to carry out treatment, payment, or health care operation of the practice. City Cardiology Associates is not required to agree to the restrictions that I may request. However, if City Cardiology Associates agrees to a restriction that I request, the restriction is binding on City Cardiology Associates, and it's physicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. I. Haque, Dr. T. Saleem or City Cardiology Associates have taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health care agency, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review City Cardiology Associates' Notice of Privacy Practices prior to signing this document. I have been offered a copy of City Cardiology Associates' NPP. The NPP describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation of City Cardiology Associates. The NPP for City Cardiology Associates is also provided in each office, where NPP is posted and on the web site at [CityCardio.com]. This NPP also describes my rights and the duties with respect to my protected health information.

City Cardiology Associates reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by accessing the City Cardiology Associates' web site, calling the office, and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____

Signature of Patient or Personal Representative   Date

____

Name of Patient or Personal Representative   Relationship/Authority   Date