Kern Cardiology Medical Group

-Since 1978

(Sam) Sarabjit Singh, MD. FACC. FSCAI;

____

New Patient Demographics (Confidential) (Please Print)

Date: _ _/_ _/_ _ _ _

Patient Personal Information

Patient Name: (First) ______________________ (Last) ______________________ (M) ________

Gender: ☐ Male ☐Female; Age _____ ; Race_________; Ethnicity_______; Primary Language___________

Birth date:______/____/______; Social Security # ________-_____-______ Drivers License #___________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Street Address____ Apt/Spc #________________

City_________________________ State ________________________ Zip _____________________

Home Phone: _________________ Additional Phone (Cell/Pager): ________________________

Employer______________________________ Employer Address____________________________

Occupation _____________________ Work Phone___________________________

Emergency Contact Person _________________________________

Relationship ___________________ Contact Number___________________________

Must be filled out if you are not the subscriber of the insurance

Responsible Party Name ____

Birth date_________________________ Social Security # ________-_____-__________

Relationship to Patient__________________ Responsible Party's Employer_________________________

Insurance Information (Please provide receptionist with copies of ALL valid insurance cards)

Primary Insurance _________________________ Insurance Phone# ___________________

Name of the person insured __________________________ Relationship__________________

ID#______________________________ Group# __________________________

Second Insurance __________________________Insurance Phone ______________________

ID# _________________________________ Group# __________________________

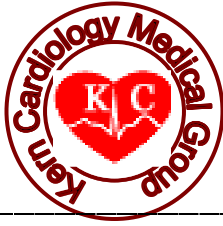
Name of the person Insured _________________________ Relationship___________________

***Who referred you to this practice?** ____

Primary Care Physician ________________________ Contact #______________________

I, the undersigned, agree that all above information is correct to the best of my knowledge.

Patient/Responsible Party Signature _____________________________ **Date:** ________



Kern Cardiology Medical Group

-Since 1978

(Sam) Sarabjit Singh, MD. FACC. FSCAI

____

New Patient Health Questionnaire (Confidential)   Date: __________

(Please provide all the information asked to get the most effective treatment)

Patient Name:___________________________**Birth Date:** ___/____/_____________

Referring Doctor__________________________ **PCP:** ___________________________

What brings you to our office today? ______________________________________

____

****

Are you allergic to: □Iodine □ Shellfish □ Aspirin □ Tape □Latex □ Other ________________
Do you have any medication allergies? □ No. □ Yes. ______________________________
Do you have any food allergies? □ No. □ Yes. ____________________________________
Are you currently on coumadin? □ No. □ Yes. Who follows? ______________________

I. Symptoms: Please check any symptoms from the list below that you have, so we can find out more about it:

	Angina		Arrhythmia		Abnormal EKG
	Sleep Apnea		_____________Bleeding		Dizziness/Syncope
	Chest Pains/Pressure		Diabetes (I) (II)		Kidney Disease
	Enlarged Heart		Fainting		Heart Murmur
	Heart Attack		High Blood Pressure		Rheumatic Fever
	Heart Failure		High Cholesterol		Blue lips or /finger nails
	Leg Cramps (walking)		Leg Swelling		Palpitations
	Lung Disease		GERD (reflux/indigestion)		Shortness of Breath
	Swollen Legs		Sexual Dysfunction		Stroke /TIA
	Thyroid Disease		Menopause		HIV/AIDS

Other symptoms: ____

____

II. Previous Testing/Procedures: Please check any tests from the list below that you have had before, we can request a copy of recent report:
Where_______________________________________ When________________

	Stress test		Angiogram		Angioplasty
	Ablation		EKG/ECG		Holter Monitor (24-48hrs)
	__Days Event Monitor		Carotid Ultrasound		Echocardiogram
	Lower Extremity Doppler		Thallium test		Pacemaker
	Defibrillator		Coronary CTA (CAT scan)		Stress Test

III. **Social History:** Please respond TRUTHFULLY to the following questions:

	Type	Past or Current	Amount
Alcohol			
Caffeine			
Energy Drinks			
Exercise			
Herbal			
Tobacco/Smoking			
Hobby			

IV. Personal Surgical History:

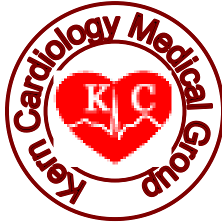
	Y/N	When (mm/dd/yy)	Complications(Y/N)
Appendectomy			
Bypass surgery			
Valve surgery			
Back surgery			
Gallbladder surgery			
Hysterectomy			
Knee surgery			
Thyroidectomy			
Other:			

V. Family Medical History:

	Father	Mother	Sister	Brother
Coronary Artery Disease				
Diabetes (type I) or (type II)				
High Blood Pressure				
High Cholesterol				
Obesity				
Stroke / CVA				
Sudden Death				
___________________Cancer				
Other:				

Pharmacy Name:

Address:______________________________ ______________________________
Phone #



Kern Cardiology Medical Group -*Since 1978*

(Sam) Sarabjit Singh, MD. FACC. FSCAI

Patient Consent Form (Confidential)

Patient Name:____________________**Birth Date:** ____/_____/__________

Please be noted that you have the right to review Kern Cardiology Medical Group's Notice of Privacy Practice before signing this patient consent form. **A copy is attached**. With your consent, Kern Cardiology Medical Group Inc. may use and disclose PHI about you to carry out treatment, payment, and healthcare options.

Acknowledgment of Receipt of the Notice of Privacy Practice

I, the undersigned, have received a copy of Notice of Privacy Practice from Kern Cardiology Medical Group Inc. I hereby understand my signature agrees that I acknowledge my rights and how my PHI will be used.

Patient/Responsible Party Initial ____________________ **Date:** _________

Insurance Authorization

I, the undersigned, have insurance coverage with ____________________ and assign directly to Kern Cardiology Medical Group Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby understand my signature requests that payment be made and authorized release information necessary to pay the claim. I authorize to this signature on all insurance submissions.

Patient/Responsible Party Initial ____________________ **Date:** _________

Authorization for Contacts

I, the undersigned, authorize Kern Cardiology Medical Group Inc. to speak to the persons listed below regarding my medical care. I hereby understand with my signature I am authorizing the release of written or oral communications by Kern Cardiology Medical Group and its staff from all legal responsibility that may arise from the act hereby authorized.

________________	________________	________________
Authorized Person	Relationship to Patient	Phone Number
________________	________________	________________
Authorized Person	Relationship to Patient	Phone Number

Patient/Responsible Party Initial____________________ **Date:** _________

Authorization for Communication

I, the undersigned, authorize Kern Cardiology Medical Group Inc. to contact me by
Email address: ___________________________Phone/Voice Mail # ________________

Mailing Address: ____

I understand that messages may at times include some protected health information, including test results and instructions. I hereby understand with my signature I am authorizing the release of written or oral communications by Kern Cardiology Medical Group and its staff from all legal responsibility that may arise from the act hereby authorized.

Patient/Responsible Party Initial______________________ Date: _________

Financial Responsibility

I, the undersigned, understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby with my signature agree to bear full financial responsibility for ALL services provided as listed below at full cost if

-Services are NOT covered under your insurance benefit plan
-Services have not been otherwise approved for payment by your insurance company
-There is no payment from your insurance

(Patient's balance not paid upon receiving the first statement is subject to $25 for late charges; returned checks are subject to $25 finance charges; An appointment not kept, cancelled or rescheduled less than 24 hours are subject to $25 finance charge; testing appointment not kept, cancelled or rescheduled less than 24 hours are subject to $50 finance charge and must be paid before visit and/or test can be rescheduled)

Patient/Responsible Party Initial ________________ Date: _________

This form is provided to you so that our office may comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By Signing below, I acknowledge that I have reviewed and agreed with the terms.

Patient/Responsible Party Signature ______________ Date ____________

Should have any questions, please contact our Office Manager at: 661-327-0807 or email her at clangille@kerncardiology.com.