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 _____

(1st) Primary Phone: _____ 2nd Phone NO: _____

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: _____

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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? _____

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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 #

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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.