



NEW PATIENT PAPERWORK
PAGE 1 OF 4

Today's Date: _____

Name: _____ Date of Birth: _____ Gender: M F

Social Security #: _____ Marital Status: S M W D

Phone: _____ Work/Cell: _____

Address (City, State, Zip): _____

E-Mail: _____ Primary MD: _____

Pharmacy: _____ Phone #: _____

Pharmacy Address: _____

Language: English Spanish Other: _____

Ethnicity:

<input type="checkbox"/>	Hispanic or Latino	(A person of Cuban, Mexican, Puerto Rican, South or Central American, other Spanish culture or origin, regardless of race)
<input type="checkbox"/>	Not Hispanic or Latino	(A person not meeting the above description for Hispanic or Latino)

REFUSED TO ANSWER

Race:

<input type="checkbox"/>	American Indian or Alaska Native	A person having origins in any of the original peoples of North, Central or South America, and who maintains tribal affiliations or community attachment
<input type="checkbox"/>	Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam"
<input type="checkbox"/>	Black or African American	A person having origins in any of the black racial groups of Africa
<input type="checkbox"/>	Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Island
<input type="checkbox"/>	White	A person having origins in any of the original peoples of Europe, the East, or North Africa

REFUSED TO ANSWER

NEW PATIENT PAPERWORK

PAGE 2 OF 4

EMPLOYMENT INFORMATION

Employer: _____ Phone: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Social #: _____ Gender: M F

Phone: _____ Work/Cell: _____

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Insured's Name: _____ Insured's Date of Birth: _____

Secondary Insurance: _____ ID#: _____

Insured's Name: _____ Insured's Date of Birth: _____

MEDICATIONS

Current Medications (list Vitamins, supplements, and over-the-counter meds): _____

Allergies: _____

Reason for Visit: _____

NEW PATIENT PAPERWORK

PAGE 3 OF 4

NAME: _____

REFERRING M.D.: _____ PRIMARY M.D.: _____

Have you had any of the following within the past six months:

- | | |
|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Any circulatory problems |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Hard to breath if you lay down flat | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Swelling of the legs, feet or hands | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Visual problems |
| <input type="checkbox"/> Light-headedness/dizziness | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tiredness | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Urinary problems |

Do you have any of the following:

Does any member of your immediate family:

- | | |
|--|--|
| <input type="checkbox"/> Alcohol usage | <input type="checkbox"/> Alcohol usage |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Angioplasty |
| <input type="checkbox"/> Asthma/ COPD | <input type="checkbox"/> Asthma/ COPD |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> By-pass surgery | <input type="checkbox"/> By-pass surgery |
| <input type="checkbox"/> Carotid artery disease | <input type="checkbox"/> Carotid artery disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Echocardiogram |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Family history of heart disease | <input type="checkbox"/> Family history of heart disease |
| <input type="checkbox"/> Gangrene | <input type="checkbox"/> Gangrene |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart catherization | <input type="checkbox"/> Heart catherization |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Heart problems as a child | <input type="checkbox"/> Heart problems as a child |
| <input type="checkbox"/> Heart valve disorders | <input type="checkbox"/> Heart valve disorders |
| <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Holter/event monitor | <input type="checkbox"/> Holter/event monitor |
| <input type="checkbox"/> Infection of the heart | <input type="checkbox"/> Infection of the heart |
| <input type="checkbox"/> Internal bleeding | <input type="checkbox"/> Internal bleeding |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Nicotine usage | <input type="checkbox"/> Nicotine usage |
| <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Peptic ulcer |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Stress test | <input type="checkbox"/> Stress test |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Thyroid |

NEW PATIENT PAPERWORK

PAGE 4 OF 4

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES AND AMOUNTS NOT PAID BY MY INSURANCE CARRIER

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED: _____ **Date:** _____

I authorize payment of medical benefits to Dr. Siva Gummadi, MD, FACC, Dr. Vijaya Koka, MD, FACC, Dr. Jayanth Koneru, MD, Dr. Hima Mikkilineni, MD, FACC, Dr. Jigar Patel, MD, Dr. Srisha Rao, MD, FACC, Dr. Prem Singh, MD, FACC, FSCAI, Dr. Paul Urban, MD, FACC, FSCAI or Cardiovascular Institute of Central Florida for services rendered to me.

SIGNED: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the
CARDIOVASCULAR INSTITUTE OF CENTRAL FLORIDA "Notice of Privacy Practices."

And

I authorize information to be disclosed with/released to another individual YES NO

Individual's Name: _____ Relationship: _____

Individual's Name: _____ Relationship: _____

I consent to information being left on my answering machine. YES NO

Name (Please Print) Signature Date

FOR CARDIOVASCULAR INSTITUTE OF CENTRAL FLORIDA

Date acknowledgement was received: _____

OR

Reason acknowledgement was not obtained: _____

Employee/Rep Name (Please Print) Signature Date: