NEW PATIENT PAPERWORK

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:

☐	Hispanic or Latino	(A person of Cuban, Mexican, Puerto Rican, South or Central American, other Spanish culture or origin, regardless of race)
☐	Not Hispanic or Latino	(A person not meeting the above description for Hispanic or Latino)

☐ REFUSED TO ANSWER

Race:

☐	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
☐	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"
☐	Black or African American	A person having origins in any of the black racial groups of Africa
☐	Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Island
☐	White	A person having origins in any of the original peoples of Europe, the East, or North Africa

☐ REFUSED TO ANSWER

NEW PATIENT PAPERWORK

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

NAME: ______________________________

REFERRING M.D.: ______________________ PRIMARY M.D.: ______________________

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

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

Do you have any of the following:

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

Does any member of your immediate family:

- ☐ Alcohol usage
- ☐ Angina
- ☐ Angioplasty
- ☐ Asthma/ COPD
- ☐ Blood clots
- ☐ By-pass surgery
- ☐ Carotid artery disease
- ☐ Diabetes
- ☐ Echocardiogram
- ☐ Emphysema
- ☐ Family history of heart disease
- ☐ Gangrene
- ☐ Heart attack
- ☐ Heart catherization
- ☐ Heart murmur
- ☐ Heart problems as a child
- ☐ Heart valve disorders
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ High cholesterol
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- ☐ Kidney problems
- ☐ Liver problems
- ☐ Nicotine usage
- ☐ Peptic ulcer
- ☐ Reflux
- ☐ Seizures
- ☐ Skin problems
- ☐ Sleep apnea
- ☐ Stress test
- ☐ Thyroid

NEW PATIENT PAPERWORK

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. Bosede Afolabi MD FHRS, 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. Kalpesh Slolanki DO FACC, 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: