CVI
Cardiovascular Institute of Central Florida

NEW PATIENT PAPERWORK

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