ACCREDITED CARDIOLOGY OF ARIZONA

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PATIENT INFORMATION RECORD

PATIENT'S FULL NAME: ______________________ ____________________ ______ ____________________
(Last) (First) (MI) (Nick Name)

☐Child ☐Single ☐Married ☐Divorced ☐Widow/Widower ☐Other

STREET ADDRESS: ____ APT __________

CITY ___________________________________ ST _______ ZIP ________

DATE OF BIRTH: ______/______/______ AGE: _________ SEX: M F

SOCIAL SECURITY No. _______ - ______ -_________ SPOUSE'S NAME: ____________________________

HOME PHONE : ( ) _________________ CELL PHONE: ( ) _________________

PATIENT'S EMPLOYER: _______________________________________ WORK PHONE: ( ) ______________

SPOUSE'S EMPLOYER: _______________________________________ WORK PHONE: ( ) ______________

PRIMARY CARE PHYSICIAN (PCP): ____________________________ PHONE ( ) ___________________

PCP ADDRESS: ____

REFERRED BY: ☐ DOCTOR (Name) _______________________ ☐ OTHER (Name) __________________________

EMERGENCY CONTACT: ______________________ RELATIONSHIP__________ PHONE ( ) ______________

PRIMARY INSURANCE NAME: ____

POLICY ID# ____ GROUP# ______________________

MAIL CLAIM FORM TO:____ __________________________

Fill Out <u>ALL INFORMATION</u> If Subscriber is Other Than Self:

INSURED NAME: _______________________________________ RELATIONSHIP TO INSURED: _____________
(As it appears on card) *(Self, Spouse,Child)*

DATE OF BIRTH: ___________________ SEX: M F SOCIAL SECURITY No. _______ - ______ -_________

SECONDARY INSURANCE NAME: ____

POLICY ID# ____ GROUP# ______________________

MAIL CLAIM FORM TO:____ ___________

INSURED NAME: _______________________________________ RELATIONSHIP TO INSURED: _____________
(As it appears on card) *(Self, Spouse,Child)*

DATE OF BIRTH: ___________________ SEX: M F SOCIAL SECURITY No _______ - ______ -_________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS: I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I ACKNOWLEDGE that I HAVE RECEIVED information regarding practice policies and procedures and that information is also available for my review at the practice website at www.accreditedcardiology.com.

____ ____________________________

Responsible Party's Signature **Date**

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GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit: ______________________

Current medications: ______________________

Allergies to medications: ______________________

Allergies (e.g. itching or hives) to specific brands of soap/detergent: ______________________

Other physicians currently treating you: ______________________

Previous or other medical problems: ______________________

List any previous surgeries or hospitalizations: ______________________

Females only: Are you pregnant, planning a pregnancy, or nursing a child? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Number of years: ___________ How much? _________________

If yes: ☐ Cigarettes ☐ Pipe ☐ Cigars Are you interested in quitting? ☐ Yes ☐ No

Do you regularly drink alcohol? ☐ Yes ☐ No How many ounces/beers per day? ____________________

Do you regularly drink coffee? ☐ Yes ☐ No How many cups per day? ____________________

Are you under stress at work? ☐ Yes ☐ No Please describe: ____________________

Do you have trouble sleeping at night? ☐ Yes ☐ No

Has anyone told you that you snore when you sleep? ☐ Yes ☐ No

PERSONAL MEDICAL HISTORY

Have you ever had any of the following? (Check all that apply):

☐ Chest pain/pressure/tightness
☐ Hypertension
☐ Heart attack
☐ Stroke
☐ Headaches
☐ Glaucoma
☐ Allergies or eczema
☐ Depression
☐ Blood in stool
☐ Asthma
☐ Dizziness
☐ Cancer
☐ Diabetes
☐ Arthritis
☐ Difficulty hearing
☐ Memory loss
☐ Hemorrhoids
☐ Kidney disease
☐ Shortness of breath
☐ TB/lung cancer
☐ Ulcers
☐ Skin disorders
☐ Hepatitis
☐ Cataracts
☐ Digestive problems
☐ Frequent urinary infections
☐ Other: ______________________

FAMILY HISTORY

Have any of your immediate family members had (currently or in the past) any of the following conditions?

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High blood pressure	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Eczema/psoriasis	☐	☐	☐	☐	☐	☐
Heart attack/stroke	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Hay fever	☐	☐	☐	☐	☐	☐