

NORTHSIDE CARDIOLOGY, P.C.

5670 Peachtree Dunwoody Road, Suite 880 Atlanta, GA 30342

610 Peachtree Parkway, Suite 100 Cumming, GA 30041

(404) 256-2525 Fax (404) 845-4720

Barry D. Silverman, M.D. Jack P. Chen, M.D. Michael A. Balk, M.D. Van Crisco, M.D.

Narendra Singh, M.D. Nabeel Hafeez, M.D. Kim P. Champney, M.D.

Marcus Brown, M.D. Mohammad Kooshkabadi, M.D.

Dear Patient:

Our physicians and staff would like to welcome you as a new patient to Northside Cardiology. We encourage you to visit our website at www.nscatl.com. In an effort to reduce your wait time, we request that you fully complete the enclosed patient forms and bring them with you, along with any insurance information, including your insurance card when you report for your visit. Please also bring your pharmacy information including Pharmacy name, address, and telephone number.

If you have a health insurance plan that requires a primary care physician referral, you need to call your physician. You may request your physician to FAX the referral to us at 404-845-4720, or you may bring it with you. If you see a specialist without a referral, your insurance plan will require you to pay in full for your visit.

Please arrive at least 30 minutes prior to your appointment time to complete all necessary paperwork and insurance forms. As a reminder, if you are late by 15 minutes after your scheduled arrival time, your visit may need to be rescheduled for another day. If you need to cancel your appointment, please give us 48 hour advance notice. You may be billed \$75.00 for a no show fee if you fail to notify our office of your cancellation. We apologize in advance if this causes any inconvenience for you, but our physicians want to make sure that you have enough time to receive the utmost in professional care.

Please be aware that all copays, deductibles and prior debts need to be paid in advance of seeing the physician or physician assistant. For your convenience, we accept all major credit cards, checks and cash.

Thank you for your attention to the above. We look forward to meeting you at your visit.

Appointment Date

Appointment Time

Arrival Time

Sincerely,

Northside Cardiology, P.C.

Patient Name _____ Date _____

Age: _____ Sex: M F

Chief Complaint: _____

Who is your Primary Care Physician? _____ Phone# _____

CARDIAC HISTORY

Do you have chest pain? Yes
If so, when did it begin? _____

What is its frequency? _____

What is the duration of pain? (seconds) (minutes) (hours) (days)

The pain worse with: (stress) (exercise) (meals) (sleep) (position) (other)

The pain is better with: (rest) (aspirin) (nitroglycerin) (other)

What does the discomfort feel like? (sharp) (aching) (burning) (tightness) (pressure)

Have you had any of the following cardiac studies? Please fill in date of study if applicable.

Exercise Treadmill Echo Nuclear Scan Catheterization
Date _____ Date _____ Date _____ Date _____

Please circle yes if this applies to you:

- Do you get any skipped heartbeats or racing heart? Yes No
- Do you have shortness of breath while lying flat? Yes No
- Do you wake up with shortness of breath? Yes No
- Do you get swelling of the ankles? Yes No
- Do you get calf pain while walking? Yes No

Please list the name, dosage and frequency of current medications:

MEDICATION	DOSAGE	FREQUENCY (HOW OFTEN)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name _____

ALLERGIC/IMMUNOLOGIC

Do you have any drug allergies? Yes No

History of skin reaction or other adverse reactions to:

Antibiotics: Name _____

Pain medication: Name _____

Anesthetics: Name _____

Blood thinners: Name _____

Contrast agents, iodine, dyes or shellfish: Name _____

Other drugs or medication: Name _____

Known food allergies: Name _____

FAMILY HISTORY

Does anyone in your family have a history of:

Heart disease Relationship _____

Heart surgery Relationship _____

Hypertension Relationship _____

Diabetes Mellitus Relationship _____

Stroke Relationship _____

Vascular problems Relationship _____

Age of mother _____ Age of father _____ Number of siblings _____

If parents or siblings are not living, please list age and cause of death:

Father- age _____ Cause _____

Mother- age _____ Cause _____

Sibling- age _____ Cause _____

CARDIAC RISK FACTORS

Please circle yes if this applies to you:

History of stroke/peripheral circulation problems? Yes No

Do you have a history of high blood pressure? Yes No number of years _____

Do you have a history of diabetes mellitus? Yes No number of years _____

Have you ever been told that you have elevated cholesterol? Yes No number of years _____

If so, what is your level? Total cholesterol _____ "Bad" cholesterol _____

Do you smoke? Yes No number of years _____ cigs per day _____

If no, have you ever smoked before? Yes No year quit _____

Do you exercise regularly at least 30 minutes 3 times per week? Yes No

Please circle appropriate exercise activity: (Walk) (Run) (Aerobics) (Sports)

Patient Name _____

PAST HISTORY

Please list any surgical procedures, major illnesses, hospitalizations and their dates:

Name	Date
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Where were you born? _____ If outside the US, what year did you come to the states? _____

How would you describe your ethnic background? _____

Do you drink alcohol? Yes No
If so, what is your weekly consumption? _____

Are you: Single Married Widow/Widower Divorced Life partner

Do you have any children? Yes No If yes, how many? _____ What are their ages? _____

Are you employed? Yes No If yes, what is your job title? _____

Occupation: Please state an accurate description of your work activity:

If retired, what did you do before? _____

What is your favorite activity? _____

Do you have any stressful problems? (please circle) Family Work
Describe: _____

Please list any questions you have for your doctor:

1. _____
2. _____
3. _____
4. _____

**NORTHSIDE CARDIOLOGY, P.C.
PATIENT INFORMATION FORM**

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient's Name: (first- middle- last) _____ Date _____
Mr./Mrs./Ms _____ Date of Birth _____ Age _____
Address _____ Marital Status _____
City _____ State _____ Zip _____ Email Address _____
Home Phone Number _____ Employer _____
Cell Phone Number _____ Address _____
SS# of Patient _____ City _____ State _____ Zip _____
Sex _____ Employer Phone Number _____

Primary Insurance Name _____ Policy # _____
Address _____ Group # _____
_____ Phone # _____
Name of Insured _____ Relationship to Insured _____
DOB of Insured _____ SS# of Insured _____

Secondary Insurance Name _____ Policy # _____
Address _____ Group # _____
_____ Phone # _____
Name of Insured _____ Relationship to Insured _____
DOB of Insured _____ SS# of Insured _____

Pharmacy Information:

Name of Pharmacy: _____
Address: _____

Telephone Number: _____

**NORTHSIDE CARDIOLOGY, P.C.
PATIENT INFORMATION FORM**

PLEASE PRINT AND COMPLETE ALL ENTRIES

Emergency Contact:

Name _____ Phone # _____

Address _____ City/State/Zip _____

Relationship _____

*****Very Important to Fill Out Below*****

Referring Physician _____ **Phone** _____
First Name *Last Name*

Primary Care Physician _____ **Phone** _____
First Name *Last Name*

PREFERRED METHOD OF PAYMENT (check one): Check Cash Credit Card

Northside Cardiology P.C.
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Northside Cardiology P.C. is committed to protecting your health information. We will not release confidential medical information regarding your care to unauthorized persons. You have the right to request us to restrict use or disclosure of your health information, including information for treatment, payment or health care operations. Northside Cardiology P.C. has no obligation to agree to the request, but will review each request carefully.

NAME: _____ **MR#** _____

SS# _____ **Date of Birth** _____ **Date of Request** _____

Northside Cardiology P.C. may:

1. **Yes** **No** Call my home, cell phone or pager and leave a message. Home # _____
Cell phone or pager _____

2. **Yes** **No** Mail information to my home or alternate location. Alternate address _____

3. **Yes** **No** Email information to me at: _____

4. **No restrictions** **Please restrict the following type of health information to be disclosed:**

- Spouse's name Home Phone Home Address Name of Employer Occupation
 Office Address Office Phone Spouse's Office Phone Medical History Treatment Notes
 Physician Notes Prescription Information Other

5. Secondary contact person: Name _____ Relationship _____

Address _____ Phone # _____

6. **Yes** **No** Northside Cardiology P.C. may review my information for purposes of research, audits and quality incentives.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Northside Cardiology P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Northside Cardiology P.C. Privacy Officer at 5670 Peachtree Dunwoody Road, Suite 880, Atlanta, GA 30342.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Northside Cardiology P.C. may decline to provide treatment to me.

My signature below constitutes my acknowledgement that Northside Cardiology P.C. is a health care provider and may share my information for treatment, payment and health care operations and I am consenting to Northside Cardiology P.C.'s use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

Signature of Patient

Date

If any person is physically unable to provide a signature or signs with a mark, print his/her name of the appropriate line below and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement.

If patient is not capable of acknowledging the notice because of age or medical condition, complete the following:

Patient is a minor (____ years of age) or Patient is unable to acknowledge because _____

Signature of Legal Guardian/ Relative

Date

Legal Guardian/ Relative Relationship

Witness

Date

Witness

Date

For Northside Cardiology P.C. use only:

Patient did not sign due to: _____