NORTHSIDE CARDIOLOGY, P.C.
TESTING LAB
PATIENT MEDICAL HISTORY INFORMATION SHEET

NAME ____ SEX __________ DATE ____________

PHONE _______________________

SS# _______________________ DOB_______________________ AGE _____________

EMAIL ADDRESS ____

HEIGHT ________ WEIGHT ________ REFERRING PHYSICIAN ___________________________

REASON FOR TEST ____

MEDICATION ALLERGIES ____

CURRENT MEDICATION	DOSAGE	FREQUENCY (HOW OFTEN)
___________________________	_________________	________________________
___________________________	_________________	________________________
___________________________	_________________	________________________
___________________________	_________________	________________________

You have or have you ever had:

YES		YES	
______	Heart disease or heart attack	______	Heart valve surgery
______	Congestive heart failure (fluid in lungs)	______	Bypass surgery
______	High blood pressure	______	Pacemaker / ICD
______	Irregular heart beat	______	TIA / stroke
______	High cholesterol	______	Difficulty walking
______	Asthma or other lung disease	______	Cancer
______	Diabetes	______	Breast implants

______ Chest pain. IF YES, what seems to cause it? ______________________________________

What makes it go away?____

______ Do you smoke? How much and for how long? ___________________________________

______ Are you pregnant?

______ Do you drink alcohol? Avg. # of drinks per week___________________

______ Family history of heart problems? If yes, please describe____________________________

____

NORTHSIDE CARDIOLOGY, P.C.

PATIENT INFORMATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient's Name: (first- middle- last)

Mr./Mrs./Ms ___________________________________

Address ____

City __________________ State __________ Zip__________

Home Phone Number _______________________________

Cell Phone Number_________________________________

SS# of Patient ______________________________________

Sex _____________

Date _____________________

Date of Birth _________________ Age _________

Marital Status______________________________

Email Address ______________________________

Employer _________________________________

Address ___________________________________

City ________________ State ________ Zip _______

Employer Phone Number ____________________

Primary Insurance Name __________________________________

Address ____

____

Name of Insured ____

DOB of Insured _______________________

Policy # _____________________________

Group # ____________________________

Phone # ____________________________

Relationship to Insured ________________

SS# of Insured ____________________________

Secondary Insurance Name ________________________________

Address ____

____

Name of Insured ____

DOB of Insured ______________________

Policy # _____________________________

Group # _____________________________

Phone # _____________________________

Relationship to Insured _______________

SS# of Insured _____________________________

Emergency Contact:

Name ____________________________________ Phone # __________________ Relationship ____________

Address __________________________________ City/State/Zip _________________________

*****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

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For Northside Cardiology P.C. use only:

Patient did not sign due to: ____.

How did you hear about our practice?

- ☐ My primary care physician
- ☐ Family member or Friend (word of mouth)
- ☐ The Radio
- ☐ Up in Cumming Magazine
- ☐ Forsyth Living Magazine
- ☐ Khabar Magazine
- ☐ Metro Atlanta Yellow Pages
- ☐ Chinese Yellow Pages
- ☐ China Journal Atlanta
- ☐ Internet Search Engine
- ☐ I saw Dr.______________ give a talk/education session
- ☐ Other:________________________________