Centennial Heart CARDIOVASCULAR CONSULTANTS

Patient Registration Form

Patient's Name (Last) _____ (First) _____ (Middle) _____

Address (NO PO BOX) _____

City _____ State _____ Zip Code _____

Phone Number _____ Work _____ Cell _____

Email Address _____

Date of Birth _____ SS # _____ Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow

Guarantor _____ SS # _____ DOB _____

Address _____ Phone # _____ Work # _____

Referring Physician _____ Primary Care Physician _____

Emergency Contact _____ Phone Number _____

Employment Status ☐ Employed ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Part-Time Student ☐ Full-Time Student

Employer _____ Phone Number _____

Employer Address _____ City _____ State _____

Primary Insurance _____ Insured SS # _____

Subscriber ID _____ Subscriber Group # _____

Name of Insured _____ Insured DOB _____

Secondary Insurance _____ Insured SS # _____

Subscribers ID _____ Subscribers Policy # _____

Name of Insured _____ Insured DOB _____

***please provide your insurance card(s) to the front desk at check-in)*

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

_____ _____

Patient (or Responsible Party) Signature Date

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☐ New ☐ Established **Patient Questionnaire**

Patient Name _____ MR# _____ Date _____

Birthday _____ Age _____ Primary Care MD or Referring MD _____

Pharmacy/Address/City/State/Zip _____ Phone # _____

Reason for today's visit _____ Recent Testing (radiology, procedure, lab work?) ☐ **Yes** ☐ **No**

What? _____ Where? _____

Any new medical problems, hospitalizations or surgeries since your last visit? _____

_____

Medical History:

Are you currently experiencing any of the following symptoms? (check Yes or No)

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	chest pain	☐	☐	chills	☐	☐	blood in urine	☐	☐	excessive snoring
☐	☐	shortness of breath	☐	☐	fever	☐	☐	blood in stool	☐	☐	cold or heat intolerance
☐	☐	fatigue	☐	☐	weight gain	☐	☐	abdominal pain	☐	☐	excessive thirst/urination
☐	☐	muscle weakness/pain	☐	☐	weight loss	☐	☐	indigestion	☐	☐	vision changes
☐	☐	exercise intolerance	☐	☐	swelling	☐	☐	nausea	☐	☐	ringing in ears
☐	☐	dizziness	☐	☐	easy bruising	☐	☐	vomiting	☐	☐	vertigo
☐	☐	passing out	☐	☐	nose bleeds	☐	☐	cough	☐	☐	seizures
☐	☐	palpitations	☐	☐	vomiting blood	☐	☐	wheezing	☐	☐	male impotence
☐	☐	pain in legs/buttocks at rest	☐	☐	pain in legs/buttocks when walking						

Are you allergic to any medications? ☐ No ☐ Yes (list) _____

_____

Are you allergic to IV Dye/Contrast? ☐ Yes ☐ No **Shellfish?** ☐ Yes ☐ No

Have you been treated for any of the following conditions? (check Yes or No)

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	high blood pressure	☐	☐	high cholesterol	☐	☐	kidney problems	☐	☐	tuberculosis (TB)
☐	☐	heart failure	☐	☐	blood clots	☐	☐	rheumatic fever	☐	☐	cancer
☐	☐	blockage of the heart	☐	☐	stroke	☐	☐	hiatal hernia	☐	☐	sleep apnea
☐	☐	blockage of the neck/leg	☐	☐	diabetes	☐	☐	stomach problems	Other _____		
☐	☐	abnormal heart rhythm	☐	☐	lung disease	☐	☐	thyroid problems			

Social History:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced **Do you have an Advanced Plan of Care/Directive?** ☐ Yes ☐ No

Work Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled **Occupation:** _____

Exercise? ☐ No ☐ Yes **What do you do and how often?** _____

Caffeine? ☐ No ☐ Yes **What and how much?** _____

Smoke? ☐ No ☐ Yes **How many packs per day?** _____ **How long?** _____ **Interested in Quitting?** ☐ No ☐ Yes

Alcohol? ☐ No ☐ Yes **What and how much?** _____

Recreational Drugs? ☐ No ☐ Yes **What and how much?** _____

Preventive Care History:

Have you received the annual flu vaccination? ☐ Yes ☐ No **Pneumonia vaccination within the last 5 yrs?** ☐ Yes ☐ No

Are you currently taking an Aspirin or other antiplatelet daily? ☐ Yes ☐ No **If other, what?** _____

Are you currently taking Warfarin or other anticoagulant? ☐ Yes ☐ No **If other, what?** _____

Family History:

Are there members of your immediate family with the following conditions or history?

Heart Disease? ☐ Yes ☐ No ☐ Who? _____ Age of 1st episode _____

Heart surgery? ☐ Yes ☐ No ☐ Who? _____ Age of 1st episode _____

Irregular heart rhythms? ☐ Yes ☐ No ☐ Who? _____ Age of 1st episode _____

Physician Signature _____