CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.

PATIENT REGISTRATION

CFCG Physician _____ Date: _____

First Name: _____ Middle: _____ Last: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Emergency Phone / Contact: _____

Marital Status: _____ DOB: _____ Social Security: _____

Referring Physician: _____

How did you hear about us? _____

Employer Name: _____

Address: _____

Phone #: _____

Insurance Information

Pre-certification telephone #: _____

Primary Insurance: _____

Address: _____

Policy #: _____ Group #: _____

Subscriber: _____ Subscriber's Social Security _____

Subscriber's Employer Name: _____

Secondary Insurance: _____

Address: _____

Policy #: _____ Group #: _____

Subscriber: _____ Subscriber's Social Security _____

Subscriber's Employer Name: _____

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as an original. I authorize said assignee to release all information necessary to secure payment. I understand I am responsible for any deductible, co-payment, and or non-covered services. In the event my account is assigned to collection, I agree to pay all cost of collection including reasonable attorney fees.

_____ _____

PATIENT'S SIGNATURE DATE

SEE BACK

CFCG-7 8/2012
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CONSENT FOR TREATMENT

I herby consent to the physicians and/or other certified practicing clinicians of Central Florida Cardiology Group, to provide clinical evaluation and treatment services. In the event of an emergency I consent to receive whatever treatment is deemed necessary.

Patient Signature: _____

Date: _____

ASSIGNMENT OF BENEFITS

I understand I am responsible for the payment of services rendered to me. I authorize Central Florida Cardiology Group to furnish information to other physicians involved in my care and to my insurance carrier(s) concerning my medical history, illness and treatment. I herby assign all medical benefits rendered to me to which I am entitled.

Patient Signature: _____

Date: _____

LIFETIME AUTHORIZATION ASSIGNMENT FOR MEDICARE BENEFICIARY

I request payment of authorized medicare benefits to be made on my behalf for any services furnished by a physician of Central Florida Cardiology Group, P.A.

I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____

Date: _____

CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.

PATIENT HISTORY (All fields required)

Date: _____ Date of Birth: _____

Name: _____ Age: _____ Ht: _____ Wt: _____ Gender: ☐ F ☐ M

Primary Care Physician: _____

Use of Recreational Drugs: ☐ Yes ☐ No Alcohol: ☐ Socially ☐ One Per Day ☐ 2 or More Per Day ☐ None

Smokeless Tobacco: ☐ Yes ☐ No	Smoking Status: ☐ Current every day smoker ☐ Current some day smoker What age did you start smoking? _____ ☐ Former smoker ☐ What age did you quit? _____ ☐ Never smoker	
Race: ☐ White ☐ Hispanic or Latino ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander	Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino	Preferred Language: ☐ English ☐ Spanish ☐ French Creole ☐ Other_____

Cardiac Problems or Questions to be addressed:

1. _____
2. _____
3. _____

CURRENT MEDICATION

MEDICATION	DOSAGE	FREQUENCY

Drug Allergies: _____

PAST HOSPITALIZATION AND/OR SURGERIES

PROCEDURE	DATE

Have you experienced any of the following (Check if YES):

☐ High Blood Pressure	☐ Elevated Cholesterol	☐ Syncope (loss of consciousness)
☐ Diabetes	☐ Palpitations	☐ Chest Pain
☐ Shortness of Breath	☐ Increased Fatigue	☐ Dizziness

PERTINENT PAST CARDIAC FAMILY HISTORY

Father: _____

Mother: _____

Brother/Sister: _____

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CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.

NEW PATIENT INFORMATION

NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY: _____

WITHIN THE LAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING?

	TEST	WHERE	PHONE #
_____	EKG	_____	
_____	Thallium (nuclear study)	_____	
_____	Open Heart Surgery (bypass)	_____	
_____	Valve Surgery	_____	
_____	Cardiac Catherization (angiography)	_____	
_____	PTCA (balloon procedure)	_____	
_____	ECHO (sonogram of the heart)	_____	
_____	Another Cardiologist	_____	

WHO IS YOUR PRIMARY/FAMILY PHYSICAN?

NAME _____

ADDRESS _____

_____

PHONE _____

I authorize the release of my medical records to the Central Florida Cardiology Group for the dates listed above. This authorization includes consent to fax the above records to the office indicated below.

FAX/MAIL RECORDS TO: CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.
1745 North Mills Avenue
Orlando, Florida 32803
Phone: (407) 841-7151
Fax: (407) 841-8572

PATIENT SIGNATURE _____ DATE _____

CFCG-8 11/2010
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Central Florida Cardiology Group, P.A.

1745 North Mills Avenue, Orlando, Florida 32803
4106 West Lake Mary Boulevard, Suite 312, Lake Mary, Florida 32746
5979 Vineland Road, Suite 114, Orlando, Florida 32819
2441 West State Road 426, Suite 2021, Oviedo, Florida 32765
1002 South Dillard Street, Suite 118, Winter Garden, Florida 34787

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

In an effort to expedite your request, please complete this form in its entirety. Central Florida Cardiology Group uses an outside company to process all requests. In accordance with the state allowance, the charge will be $1.00 per page for the first 25 pages and 0.25 thereafter and the patient rate is .12 per page, .39 per envelope plus sales tax and postage. Please allow 7-10 business days to complete this process. If you should have any questions regarding your records, please call our Health Information Management department at (407) 841-7151, Option 7 or fax to (407) 425-2768. CIOX Health renders copy services. CIOX is contracted to provide this service and will invoice you directly. If you have any questions regarding an invoice, you can contact CIOX at 1-800-367-1500.

I,_____ date of birth of _____authorizes Central Florida Cardiology

Group, P.A. to furnish a copy of my medical records for the period from _____ to _____.

Release to _____
Name of individual or company receiving records

Address_____
Address City State Zip code

Email: _____ Phone: _____ Fax: _____
(PLEASE PRINT LEGIBLY)

PURPOSE OF DISCLOSURE:

- ☐ CONTINUITY OF CARE
- ☐ PERSONAL
- ☐ LEGAL
- ☐ DISABILITY
- ☐ INSURANCE
- ☐ WORKERS COMP

TO BE RELEASED:

- ☐ OFFICE CONSULTATION
- ☐ HOLTER
- ☐ CARDIAC CATHETERIZATION
- ☐ EKG
- ☐ STRESS TEST
- ☐ LAB WORK
- ☐ ECHOCARDIOGRAM
- ☐ NUCLEAR/PET TEST
- ☐ 2- YEAR CHART ABSTRACT

OTHER (SPECIFY): _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signed: _____ Date: _____

CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.

Dear Patient,

We want to make you aware of a condition that may affect you. As many as 12 million Americans have **Peripheral Arterial Disease (PAD).** It is a condition in which the arteries that carry blood to the muscles of the legs become narrowed or blocked due to the build up of plaque. Blood flow becomes sluggish and **poor circulation** in the legs, feet and toes may result. This may then lead to cramping, discomfort or possibly a mild "fatigue" in the legs which can limit walking distance, speed and overall ability. This is the same disease process that causes blockages in the heart.

Unfortunately, many people with PAD go dangerously unrecognized and may have a higher risk for a heart attack, stroke, or even amputation. The symptoms of PAD may be subtle and are often mistaken for arthritis, being "out of shape," or as part of the normal aging process. Many times it can be simply diagnosed by performing a calculation after taking a blood pressure in your arms and at your ankles.

Please take a moment to answer the questions below so that we may briefly screen you for PAD. If you have any questions or concerns regarding PAD and your risk, or would just like more information please do not hesitate to ask.

1) Do you experience discomfort or aching in the muscles of your legs when you walk that is relieved by rest? YES NO

2) Do your legs ever feel fatigued or heavy when walking or are active? YES NO

3) Do you ever need to stop and rest when walking or have difficulty keeping up with others? YES NO

4) Do your feet or toes bother you on most nights while lying in bed with relief when they are dangled at the edge of the bed? YES NO

5) Any prior ulcers on your feet or lower legs? YES NO

6) Would you have difficulty or require assistance doing any of the following?

	No Difficulty	Some Difficulty	Unable
Walking one block?	1	2	3
Climbing one flight of stairs?	1	2	3
Walking at an increased speed?	1	2	3

7) Please check if you have a history of the following.

[ ] Diabetes or "borderline" diabetes [ ] Age ≥ 70 years

[ ] Smoking or history of smoking or tobacco use

Name_____ Date of Birth _____ Date_____

CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.

PATIENT HISTORY, REVIEW OF SYSTEMS FORM

Patient Name _____ Date _____

Date of Birth _____ Age _____ Gender _____ (Male or Female)

General Practitioner/Primary Doctor _____ Referring Physician/Specialist _____

REVIEW OF SYSTEMS – PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

Race:
- ☐ White
- ☐ Hispanic or Latino
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ French Creole
- ☐ Other _____

CONSTITUTIONAL	YES	NO
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Change in Appetite	☐	☐

EYES	YES	NO
Glasses/Contacts	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

EAR, NOSE, THROAT	YES	NO
Ringing in ears	☐	☐
Vertigo	☐	☐
Frequent Sore Throat	☐	☐
Hoarseness	☐	☐
Frequent Nosebleeds	☐	☐

GENITOURINARY	YES	NO
Pain Urinating	☐	☐
Burning	☐	☐
Frequency	☐	☐
Nighttime	☐	☐
Blood in Urine	☐	☐
Vaginal Discharge	☐	☐
Penile Discharge	☐	☐
History Sexually Transmitted Disease	☐	☐

ALLERGIC/IMMUNOLOGIC	YES	NO
Hay Fever	☐	☐
Asthma	☐	☐
Hives/Eczema	☐	☐

RESPIRATORY	YES	NO
Shortness of Breath	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Persistent Cough	☐	☐
Frequent Infections	☐	☐

GASTROINTESTINAL	YES	NO
Abdominal Pain	☐	☐
Nausea/Vomiting	☐	☐
Heartburn	☐	☐
Rectal Bleeding	☐	☐
Bloody/Black Stools	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐

CARDIOVASCULAR	YES	NO
Chest Pain	☐	☐
Jaw Pain	☐	☐
Arm Pain	☐	☐
Calf Pain	☐	☐
Palpitations	☐	☐
Swelling of Extremities	☐	☐

PSYCHIATRIC	YES	NO
Anxiety	☐	☐
Depression	☐	☐
Mood Swings	☐	☐
Sleep Disorder	☐	☐

HEMATOLOGIC	YES	NO
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
Prolonged Bleeding	☐	☐

MUSCULOSKETLETAL	YES	NO
Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐

NEUROLOGICAL	YES	NO
Seizures	☐	☐
Headaches	☐	☐
Numbness	☐	☐
Memory Loss	☐	☐
Loss of Consciousness	☐	☐

SKIN	YES	NO
Rash/Sores	☐	☐
Lesions	☐	☐
Itching	☐	☐
Burning	☐	☐

ENDOCRINE	YES	NO
Loss of Hair	☐	☐
Heat/Cold Intolerance	☐	☐
Change in Nails	☐	☐

CARDIAC problems / questions to be addressed at this visit: _____

Past Patient History – Please list below **ALL** your past Operations, Hospitalizations, Illnesses/Injuries
PLEASE BE SPECIFIC AS TO REASON AND DATES

Please List All Past Operations/Hospitalizations with Reason and Date	Please List All Personal Illnesses/Injuries and Dates

Past Patient History – PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR PAST PERSONAL HISTORY

CONDITION	YES	NO	CONDITION	YES	NO
Infectious Diseases			**Endocrine**		
Hepatitis	☐	☐	Diabetes	☐	☐
HIV/AIDS	☐	☐	Thyroid Problems	☐	☐
Polio	☐	☐	**Gastrointestinal**		
Rheumatic Fever	☐	☐	Stomach Ulcer	☐	☐
Tuberculosis	☐	☐	Gallstones	☐	☐
Cardiovascular			Liver Disease	☐	☐
High Cholesterol	☐	☐	**Renal / Genitourinary**		
High Blood Pressure	☐	☐	Kidney Disease	☐	☐
Birth Defect of Heart	☐	☐	Kidney Stones	☐	☐
Heart Murmur	☐	☐	Prostate Problems	☐	☐
Pericarditis	☐	☐	Urinary Tract Infections	☐	☐
Heart Attack	☐	☐	**Musculoskeletal**		
Previous Stent or Angioplasty	☐	☐	Gout	☐	☐
Irregular Heart Beats	☐	☐	Arthritis	☐	☐
Peripheral Vascular Disease	☐	☐	Back Pain	☐	☐
Pulmonary and Neurologic			Herniated Disc	☐	☐
Lung Disease	☐	☐	**Hematologic / Oncology**		
Prior Pneumonia	☐	☐	Anemia	☐	☐
Exposure to Inhaling Hazardous Agent	☐	☐	Cancer-List type	☐	☐
Stroke / TIA	☐	☐	Blood Clots	☐	☐
Migraines	☐	☐	Bleeding Problems	☐	☐
Seizure Disorder	☐	☐			

Past Family History – PLEASE COMPLETE THE FOLLOWING TABLE

	Age if Alive	Health Problems	Age at Death	Cause of Death
Mother				
Father				
Siblings				
Grandparents				

Please List All Current Prescription Medications or Over the Counter Medications and Dosages					
Med Name	**Dose**	**Frequency (# times per day)**	**Med Name**	**Dose**	**Frequency (# times per day)**

Are there any medications which you stopped taking in the past month: Yes _____ No _____

If you answered "yes", which medications have you stopped? _____

Are you currently taking Aspirin? Yes ☐ No ☐ How often? _____

Are you allergic to any medication? Yes ☐ No ☐ List what medication(s) _____

Describe the type of allergic reaction you had to this medication _____

_____

Social History – Patient PLEASE ANSWER THE FOLLOWING QUESTIONS

Smokeless Tobacco: ☐ Yes ☐ No

Smoking Status: ☐ Current every day smoker ☐ Current some day smoker
What age did you start smoking? _____
☐ Former smoker What age did you quit? _____
☐ Never smoker

YES	NO	
☐	☐	Drink alcohol? If yes, please list type and quantity: _____
☐	☐	Use recreational drugs? What type _____
☐	☐	Exercise? Type _____ Miles _____ Times/day/week _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Widower

Current Occupation: _____

Have you recently traveled outside of the United States? ☐ Yes ☐ No

If you answered "yes", where did you travel to and when? _____

Patient Up Date Form

Patient **DOB**

1. Please CHECK one choice from the options below.

- □ White
- □ Hispanic or Latino
- □ Black or African American
- □ American Indian or Alaska Native
- □ Asian
- □ Native Hawaiian or Other Pacific Islander

2. Please CHECK one of the two options below that best describes you.

- □ Not Hispanic or Latino
- □ Hispanic or Latino

3. Please CHECK your Preferred Language. If it is not listed please specify.

- □ English
- □ Spanish
- □ French/Creole
- □ Other: _____

4. Please CHECK the description that best describes your smoking habits.

- □ Current every day smoker
- □ Current some day smoker
- □ Former smoker
- □ Never smoker

If you use/used tobacco what type? □ Cigarette □ Cigar □ Pipe □ Chews □ Snuff

Age you started to smoke _____

Age you stopped _____

Amount per day _____

5. Please CHECK the description that best describes your drinking habits.

□ Current user of alcohol □ Never □ Former user of alcohol , if so how many per week_____

Type of Alcohol □ Beer □ Wine □ Distilled Spiritis □ Liquer □ Cider □ Cocktails

Number of drinks per day? ____

CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices (the "Notice"). The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. In addition, I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling Ajay Thakur MD at
407-841-7151 or by requesting one at our Company's offices.

Signature of patient or patient representative: _____

Date:_____

Printed name of patient or patient representative: _____

Relationship to patient:_____

ACKNOWLEDGMENT OF RECEIPT OF BILLING AND COLLECTIONS POLICY AND PROCEDURE

I have received a copy of the Billing and Collections Policy and Procedure. I acknowledge and understand that I am responsible for all charges incurred for my care.

Signature of patient or patient representative: _____

Date:_____

Printed name of patient or patient representative: _____

Relationship to patient:_____