OLNEY MEDICAL GROUP
PATIENT REGISTRATION FORM (CARDIOLOGY)

Last name: ______________________________ First name: ____________________________MI:______________

DOB: ________/__________/________________ Sex: M ☐, F ☐

Race: Asian ☐, Black ☐, Hispanic ☐, White ☐, Other:

____

Marital Status: Single ☐, Married ☐, Divorced ☐, Widowed ☐, Separated ☐

Street address:____

City: ______________________________________State:___________________________Zipcode:______________

Cell Phone: (_______)________________________ Home/Work Phone: (_______)_________________________

Email: ____ SSN:______________________________

Insurance name: ___________________________________ID:_____________________________ NO Insurance ☐

Emergency Contact: _______________________________________ Relationship:____________________________

Cell Phone: (_______)________________________ Home/Work Phone: (_______)_________________________

Preferred Pharmacy Name and Address :____

Pharmacy Phone Number (______) ____________________ Pharmacy Fax Number (________)______________

Primary Care Name and Address :____

____

PCP Phone Number (______) ____________________ PCP Fax Number (________)_______________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

A. I have read the notice of privacy practices and I have been provided an opportunity to receive it.
B. **Assignment of insurance benefits:** I hereby direct payment of surgical medical benefits to **OLNEY MEDICAL GROUP** for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.
C. **Authorization to release information:** I hereby authorize **OLNEY MEDICAL GROUP** to release any medical care or incidental information that may be necessary for either medical care or in processing applications for financial benefit.
D. **Medical record policy**: I hereby authorize **OLNEY MEDICAL GROUP** to release my medical record to: ____________________________________ Relationship: ______________________________________
E. **Insurance card and ID policy**: I understand that I must bring a physical insurance card and a current form of ID to every appointment. Without both physically present, I may be asked to reschedule my appointment. Picture of the insurance card or photo ID on your phone will not be accepted. Nor can we accept for copies to be emailed to the office, as that is a violation of HIPAA Regulations.
F. **Controlled pain medication/sleep medicine policy**: I understand that this office does **NOT** refill chronic pain and sleep medications. If needed, the office will give me a referral for pain management or psychiatrist.

Patient's Signature : _________________________________ Date:_________________________________

Ongoing medical problems: ____

____

Past medical/major history: ____

____

Past surgical history:____

____

Medications (Indicate Strength and Directions):**

____

____

____

Allergies (Indicate if MILD, MODERATE, or SEVERE**):

Drug: No ☐, Yes ☐, If yes ____

Food: No ☐, Yes ☐, If yes ____

Environmental: No ☐, Yes ☐, If yes ____

Social history:

Tobacco use: Never ☐, Former ☐, 1-9 Cigs/Day ☐, 10-19 Cigs/Day ☐, 20-39 Cigs /Day or more ☐

Alcohol use: Never ☐, Former ☐, Monthly or less ☐, 2-4 Times/Month ☐, 2-3 Times/Week ☐, 4 or more/Week ☐

Family health history:

Diabetes: No ☐, Father ☐, Mother ☐, Sibling ☐, Other____________________________

Hypertension: No ☐, Father ☐, Mother ☐, Sibling ☐, Other____________________________

Heart problem: No ☐, Father ☐, Mother ☐, Sibling ☐, Other____________________________

Cancer: No ☐, Father ☐, Mother ☐, Sibling ☐, Other____________________________

Profession/Occupation:____

Patient's Signature: ______________________________ Date: ______________________________