COASTAL HEART INSTITUTE

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12345 Mercy Blvd.
Savannah, Georgia 31419

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Cardiology

Dear Patient,

We at Coastal Heart Institute wish to take a moment to welcome you to our Cardiology practice!

We want you to know that we appreciate the opportunity to take care of your healthcare needs, and we look forward to serving you. Your health is our primary concern. Our philosophy is to provide comprehensive care while treating every patient with dignity and respect. We offer a wide variety of clinical services to address your physical well-being.

In order to expedite the new patient registration process, we ask that you **complete** the enclosed patient information forms and bring the forms with you at the time of your appointment. Please **DO NOT** send them back in the mail. Completing this information ahead of time allows us to see you in a timely manner upon your arrival at our office, and ensures we have the information necessary to fully address your healthcare needs.

In addition, please bring the following items with you:

- A photo ID
- Your insurance card(s)
- Your copayment (if required by your plan)
- A list of any medications you are currently taking
- Any recent imaging on disk format or test results that pertain to your illness

Should you need to reschedule or cancel your appointment, please call us at least twenty-four hours in advance to allow us the courtesy of offering your spot to another patient

Thank you for choosing Coastal Heart Institute for your healthcare needs!

Patient Information			Primary Care Physician Referring Physician
Last Name	First Name	M	Nickname

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Address	City	State	Zip Code

Phone (Home)	(Cell)	Birthdate(MM/DD/YYYY) Male ❑ Female ❑

Marital Status Single ❑ Married ❑ Divorced ❑ Widowed ❑	Social Security Number

Ethnicity Non-Hispanic or Non-Latino❑ Hispanic/Latino ❑	Race	Language ❑ English Other:_____

Guarantor Information

Last Name First Name M	Relationship to Patient

Address	City	State	Zip Code

Phone (Home)	(Cell)	Birthdate(MM/DD/YYYY)

Social Security Number	Employer

Employer Information

Occupation	Employer

Employer Address	City	State	Zip Code

Work Phone	Extension

Insurance Information on Primary

Insurance Company Name	Effective Date of Coverage	Co-Payment Amount

Address	City	State	Zip Code

ID/Policy Number	Group Number/Name

Subscriber/Insured Name	Relationship to Patient

Social Security Number	Birth Date (MM/DD/YYY)

Continued next page:

Insurance Information on Secondary

Insurance Company Name	Effective Date of Coverage	Co-Payment Amount

Address	City	State	Zip Code

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ID/Policy Number	Group Number/Name
Subscriber/Insured Name	Relationship to Patient
Social Security Number	Birth Date (MM/DD/YYY)
Insurance Information on Secondary	

Emergency Contact

Name #1		Relationship to Patient
Home Phone	Cell Phone	Work Phone
Name #2		Relationship to Patient
Home Phone	Cell Phone	Work Phone

Assignment and Release

Authorization to treatment and release information to insurance carrier for direct payment to the provider. I authorize treatment and the release of any medical information (acquired in my treatment) to process claims to my insurance company. I authorize direct payment from my insurance company to my provider. At any time I decide that I want to file my own claims, understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred.

Patient Signature _____ Date _____

Patient Medical History

Today's Date: _____ Date of Last Physical Exam: _____

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Last Name: _____ First Name: _____ Middle: _____

Chief Complaint:
What is the main reason for your visit today? *(Describe your problem in detail)* _____

_____

HISTORY OF PRESENT ILLNESS

Location of the problem:

_____

How long does the problem last?

_____

On a scale of 0-10, with 10 being the most painful, circle the number that best describes the problem.

0 1 2 3 4 5 6 7 8 9 10

Is anything else occurring at the same time?
Yes No If yes, please explain.

_____
_____

When did you first notice the problem?

_____

Is the problem constant or variable?
Dull then sharp Very sharp then stops

Other _____

MEDICAL HISTORY

- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Seizure Disorder
- ❑ Cancer
  Organ _____
- ❑ Diabetes
- ❑ Gall Bladder Disease
- ❑ Heart Disease/Heart Attack
- ❑ Stroke/Mini-stroke
- ❑ High Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Thyroid Disease
- ❑ Lung Problems
- ❑ Migraines
- ❑ Neck/Back Problems
- ❑ Reflux/Heart Burn
- ❑ Tuberculosis
- ❑ Other_____

PROCEDURE HISTORY

Surgery	Date (year)	Surgery	Date (year)
❑ Heart Bypass/Valve Replacement	_____	❑ Organ Transplant	_____
❑ Hernia Repair	_____	❑ Stomach Surgery	_____
❑ Gallbladder Removed	_____	❑ Appendix Removed	_____
❑ Joint Replacement	_____	❑ Back/Neck Surgery	_____
❑ Bladder/Kidney Surgery	_____	❑ Prostate Surgery	_____
	_____	❑ Tonsils Removed	_____
		❑ Other_____	_____

Patient Printed Name: _____ Date _____

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FAMILY HISTORY

List all serious illnesses in your **immediate family**. *Examples include Seizures, Headaches, Tremors, Dementia, etc.*

Illness	Relationship
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Tobacco Use:
- ❑ Every Day
- ❑ Some Days
- ❑ Former Smoker
- ❑ Never Smoked

Type:
- ❑ Cigarettes
- ❑ Cigars
- ❑ Smokeless
- ❑ Pipe
- ❑ Other _____

Use Per Day _____ Number of Years Used _____

If past use, age started _____ Stopped at What Age _____

Alcohol Use:
- ❑ Current Use
- ❑ Past Use
- ❑ Never Used

Type:
- ❑ Beer
- ❑ Wine
- ❑ Liquor
- ❑ Other _____

Frequency:
❑ Daily ❑ 3-5 times/week ❑ 1-2 times/week ❑ 1-2 times/month ❑ 1-2 times/year

If past use, how long ago quit _____

Illicit Drug Use:
- ❑ Current Use
- ❑ Past Use
- ❑ Never Used

Type:
- ❑ Amphetamines
- ❑ Cocaine
- ❑ Ecstasy
- ❑ Hallucinogens/LSD
- ❑ Heroin
- ❑ Inhalants/Glue
- ❑ Marijuana
- ❑ Methamphetamines
- ❑ Other _____

Frequency:
❑ Daily ❑ 3-5 times/week ❑ 1-2 times/week ❑ 1-2 times/month ❑ 1-2 times/year

If past use, how long ago quit _____

Allergies: Name	What kind of reaction do you have?
_____	_____
_____	_____
_____	_____

Patient Printed Name: _____ Date _____

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MEDICATION LIST

Are you taking any medications? **Yes or No** ***(If yes, list all)***

	Name/Dosage	How often do you take this medicine?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Patient Printed Name: _____ Date _____

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Patient Review of Systems

Do you now have any problems related to the following systems?
Circle Yes or No
Please explain any yes answers in the space to the right

Gastrointestinal

Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Heartburn	Y	N
Burping	Y	N
Blood in stool	Y	N

Other _____

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Sweating	Y	N
Weight loss	Y	N
Weakness	Y	N

Other _____

Eyes

Blurred Vision	Y	N
Double Vision	Y	N

Other _____

Ear / Nose / Throat

Ear pain	Y	N
Hard of hearing	Y	N
Sore throat	Y	N
Runny nose	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Memory problems	Y	N
Frequent headaches	Y	N

Other _____

Endocrine

Excessive Thirst	Y	N
Fatigue	Y	N

Other _____

Female Genitourinary

Frequent urination	Y	N
Urgent urination	Y	N
Pain on urination	Y	N
Vaginal discharge	Y	N
Urine leakage	Y	N
Lower abdominal pain	Y	N
Blood in urine	Y	N
Painful menstruation	Y	N

Other _____

Cardiovascular

ChestPain	Y	N
Shortness of Breath	Y	N
Varicoseveins	Y	N
Palpitations	Y	N
Swelling of extremities	Y	N

Other _____

Skin

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Change in fingernails	Y	N
Hair loss	Y	N

Other _____

Musculoskeletal

Joint pain	Y	N
Back pain	Y	N
Neck pain	Y	N

Other _____

Hematologic / Lymphatic

Swollen glands	Y	N
Easy bruising	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Sputum	Y	N

Other _____

Allergic / Immunologic

Seasonal allergies	Y	N
Sneezing	Y	N
Watery/Itchy	Y	N

Other _____

Male Genitourinary

Pain in the testicles	Y	N
Penile discharge	Y	N
Blood in urine	Y	N
Night time urination	Y	N
Frequent urination	Y	N
Dribbling of urine	Y	N
Difficulty starting urine	Y	N

Other _____

Patient Printed Name: _____ Date _____

SAVANNAH MEDICAL GROUP

12345 Mercy Blvd, Savannah, GA 31419

QUESTIONS ABOUT YOUR INSURANCE

Is Dr **Drake** a preferred provider for your insurance company? Yes ___ No ___

Do you have a yearly deductible? Yes ___ No ___

If yes, amount per year $ _____

Has your deductible been met? Yes ___ No ___

Do you have a co-pay for office visits? Yes ___ No ___

Does your insurance company cover office visits? Yes ___ No ___

Does your insurance company have a preferred laboratory for lab testing? Yes ___ No ___

If yes, who? _____

Does your insurance company have a preferred hospital? Yes ___ No ___

If yes, who? _____

Providing our office with this information will prevent you from incurring unnecessary medical expenses.

Your signature below indicated that you have verified your insurance benefits and understand that you will be financially responsible for all non-covered and denied charges in addition to your normal percentage and/or co-pay.

Patient Signature: _____ Date: _____

Patient Name Printed: _____

SAVANNAH MEDICAL GROUP

12345 Mercy Blvd, Savannah, GA 31419

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION

And

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

1) I authorize this office to release or resolve any information necessary to expedite insurance claims.
2) I authorize this office to bill my insurance company directly for their expenses.
3) I authorize payments directly to this physician for any insurance benefits otherwise payable to me.
4) In the event I receive payment from my insurance company, I agree to endorse any payments I have received over to my physician for which these fees are payable

FINANCIAL POLICY

We strongly feel that al patients deserve from us the very best medical care that we can provide. Further, we feel everyone benefits when definitive financial arrangements are agreed upon. Our professional services are rendered to you, not the insurance company; therefore, payment for treatment is your responsibility. Accordingly, we have prepared this material to acquaint you with our policy.

1) I understand it is my responsibility to obtain referrals from any primary physician or health plan prior to my appointment.
2) I understand I am directly and fully financially responsible to the physician(s) or physician assistant for charges not covered by my insurance.
3) I further understand that such payment is not contingent upon any settlement, judgment, or insurance payment by which I eventually recover said fee.
4) I understand if any insurance company fails to pay my balance in full within ninety (90) days, or there is no payment made within ninety (90) days, It is my responsibility to pay my doctor's bill directly.
5) I further understand and agree that I will be responsible for any and al costs of collections, including collection agency fees, filing fees and attorney fees.

Patient Signature: _____ Date: _____

Patient Name Printed: _____

SAVANNAH MEDICAL GROUP

12345 Mercy Blvd, Savannah, GA 31419

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/MEDICAL INFORMATION

I hereby authorize Savannah Medical Group to release/receive information from the medical records of:

Patient: _____ SS#: _____

Date of Birth: _____ Date of Service: _____

Release to/from: _____

Purpose or need for information: _____

_____

I am aware of my specific waive and privilege regarding the following information which may or may not be considered in these records:

1) Communications between patient and psychiatrist.
2) Communications between patient and psychologist.
3) Medical information concerning alcohol and/or drug dependency.
4) Medical information concerning alcohol and/or drug abuse.
5) Medical information concerning mental retardation.
6) Medical information concerning acquired Immune Deficiency Syndrome.

This release is subject to revocation at any time.

Patient Signature: _____ Date: _____

Patient Name Printed: _____

SAVANNAH MEDICAL GROUP

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AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name: _____ Date of Birth _____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members. you must sign this form. Signing this form will only give information to family members indicated below. I authorize Savannah Medical Group to release my medical and/or billing information to the following individual(s):

1) Name: _____ Relation to Patient: _____

2) Name: _____ Relation to Patient: _____

3) Name: _____ Relation to Patient: _____

Patient information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above noted individual is no longer protected by federal or state law and may be subject to re-disclosure by the above noted individual. You have the right to revoke this consent in writing.

Patient Signature: _____ Date. _____

Patient Name Printed: _____