FOLSOM CARDIOLOGY

Please complete forms in black ink only

Registration Form

Office Use Only: Patient Acct # _____

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Phone: _____ Work: _____ Cell: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W Gender: ☐ M ☐ F Spouse Name: _____

Race:☐AmericanIndian ☐ Asian ☐ African American ☐Caucasian ☐ Other_____

Ethnicity: ☐ Hispanic origin ☐ Non-Hispanic origin ☐ Other _____

Language: _____

Email: _____ Driving License # _____

Occupation _____ Employer _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Cell: _____

Primary MD: _____ Referring MD _____

PRIMARY INSURANCE	SECONDARY INSURANCE
Name: _____	Name: _____
Group # _____	Group # _____
ID # _____	ID # _____
Subscriber: _____	Subscriber: _____

OUR INSURANCE BILLING POLICY:

We will bill your insurance (s) for services rendered by Folsom Cardiology Inc. If your plan requires a referral or authorization , we must have referral or authorization on file prior to your visit. You are responsible for any balance not covered or authorized by your insurance(s). We require a minimum of 24 hour notice for cancellation of appointments. You may be billed for missed appointments with inadequate notice.

I AUTHORIZE DIRECT PAYMENTS OF MEDICAL BENEFITS TO Folsom Cardiology Inc.

I also authorize the release of any information about me that is necessary to process my insurance claims. A copy of this authorization may be used in place of the original authorization.

We understand that insurance coverage is confusing to many people, and we are committed to helping you with any questions you may have. Please contact our office at (916)-597-2687 if you have any questions about this authorization.

I have read and understand the policy stated above.

INSURED SIGNATURE: _____ DATE: _____

MEDICATIONS

List of All Medications (include dose and frequency): Include over the counter medications

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

List of Allergies and Reactions: (Rash, Difficulty Breathing, Swelling, Nausea etc.)

_____

_____

_____

_____

MEDICAL HISTORY

Medical History (check if you have experienced any of the following problems in the last 6 months and explain if appropriate)

General Well-being
- ☐ Fatigue/Weakness
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Weight Gain
- ☐ Weight Loss

Eyes
- ☐ Blurred or Double vision
- ☐ Corrective Lenses
- ☐ Eye Disease or Injury
- ☐ Glaucoma

Ears, Nose, Mouth, Throat
- ☐ Difficulty Swallowing
- ☐ Hearing Difficulties
- ☐ Neck Injury
- ☐ Nose Bleeds
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Other Disease _____

Respiratory (Lungs)
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Other Disease _____

Gastroenterology (Abdomen)
- ☐ Abdominal Pain or Heartburn
- ☐ Acid Reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Ulcers
- ☐ Intestinal Disease _____
- ☐ Gallbladder Disease
- ☐ Jaundice _____
- ☐ Cirrhosis of the Liver
- ☐ Hepatitis
- ☐ Other Disease _____

MEDICAL HISTORY continued

Cardiovascular (Heart)
- ☐ Abnormal Heart Rhythms/Palpitations
- ☐ Arm, Neck or Jaw Pain
- ☐ Chest Pain
- ☐ Defibrillator/Type _____
- ☐ High Blood Pressure
- ☐ Leg Pain
- ☐ Pacemaker/Type _____
- ☐ Prior Angiogram Date _____
- ☐ Prior Balloon Angioplasty/Stent Date _____
- ☐ Prior Heart Attack Date _____
- ☐ Prior Heart Surgery Date _____
- ☐ Prior Vascular Surgery or Procedure
- ☐ Shortness of Breath
- ☐ Dizziness/Syncope
- ☐ Rheumatic Fever
- ☐ Murmur
- ☐ Other Disease _____

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Psychosis
- ☐ Schizophrenic
- ☐ Other Disease

Endocrine
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Over Weight
- ☐ Thyroid Gland Disease
  Type _____

Infections
- ☐ Hepatitis Type
- ☐ Herpes Zoster (Shingles)
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Scarlet Fever

Oncology
- ☐ Cancer
  Type _____
- ☐ Cancer Treatment
  Type _____

Hematology (Blood Disorder)
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clots
- ☐ Transfusions
- ☐ Other Disease _____

Urinary
- ☐ Bladder Disease
- ☐ Difficult or Painful Urination
- ☐ Incontinence
- ☐ Kidney Disease _____
- ☐ Kidney Stones
- ☐ Dialysis
- ☐ Other Disease _____

Musculoskeletal
- ☐ Joint Pain
- ☐ Arthritis
- ☐ Back Injury or Surgery
- ☐ Muscle Problems
- ☐ Other Disease _____

Skin
- ☐ Rashes
- ☐ Ulcers
- ☐ Other Disease _____

Neurologic
- ☐ Alzheimer's Disease
- ☐ Brain Injury
- ☐ Convulsions/Seizures
- ☐ Dizziness
- ☐ Insomnia
- ☐ Memory Loss or Confusion
- ☐ Migraines or Headaches
- ☐ Numbness
- ☐ Stroke
- ☐ Weakness
- ☐ Other Disease _____

Extremities
- ☐ Swelling
- ☐ Other Disease _____

For Woman
- ☐ Post-Menopausal
- ☐ Uterine Disease
- ☐ Vaginal Bleeding
- ☐ Other Disease _____

For Men
- ☐ Prostate Disease
- ☐ Sexual Dysfunction
- ☐ Other Disease _____

Do you have any history of:
- ☐ Stent Thrombosis
- ☐ Bleeding (Major)
- ☐ Stroke/Brain Hemorrhage
- ☐ Complication during Surgery or Anesthesia

List all Current Symptoms

_____

_____

_____

_____

_____

List All Surgeries and Approximate Dates

_____

_____

_____

_____

_____

List All Injuries and/or Accidents

_____

_____

_____

_____

_____

FAMILY HISTORY	If Living	If Deceased
	Age Medical History (Circle one)	Age of Death Cause
Father _____	____ Heart Disease Stroke Diabetes Cancer None	____ _____
Mother _____	____ Heart Disease Stroke Diabetes Cancer None	____ _____
Siblings (First Names)		
_____ ☐ M ☐ F	____ Heart Disease Stroke Diabetes Cancer None	____ _____
_____ ☐ M ☐ F	____ Heart Disease Stroke Diabetes Cancer None	____ _____
_____ ☐ M ☐ F	____ Heart Disease Stroke Diabetes Cancer None	____ _____
_____ ☐ M ☐ F	____ Heart Disease Stroke Diabetes Cancer None	____ _____
_____ ☐ M ☐ F	____ Heart Disease Stroke Diabetes Cancer None	____ _____
Children (First Names)		
_____ ☐ M ☐ F	____ Heart Disease Stroke Diabetes Cancer None	____ _____
_____ ☐ M ☐ F	____ Heart Disease Stroke Diabetes Cancer None	____ _____
_____ ☐ M ☐ F	____ Heart Disease Stroke Diabetes Cancer None	____ _____
_____ ☐ M ☐ F	____ Heart Disease Stroke Diabetes Cancer None	____ _____
_____ ☐ M ☐ F	____ Heart Disease Stroke Diabetes Cancer None	____ _____

SOCIAL HISTORY

Tobacco Use:

- ☐ Current every day smoker
- ☐ Current occasional smoker
- ☐ Never smoker
- ☐ Former smoker
- ☐ Unknown if ever smoked

If YES, Number of years and daily use

- ☐ Cigarettes _____
- ☐ Cigars _____
- ☐ Pipe _____
- ☐ Chewing Tobacco _____

If you have quit, how old were you when you quit? _____
What was your daily use at that time? _____
How many years were you a smoker? _____

Alcohol Use

- ☐ Never Drank
- ☐ Number of alcoholic drinks in a week _____

Caffeine Use

- ☐ Never use caffeine
- ☐ Number of caffeine drinks in a week _____

Recreational Drug Use

- ☐ Never used
- ☐ Type and frequency
  - Now _____
  - In the past _____

Exercise Regimen _____

Do you have Chest Pain with exercise? ☐ Yes ☐ No, If yes ☐ Mild ☐ Moderate ☐ Severe

Questions for your Physician:

_____

_____

_____

Authorization for Use or Disclosure of Protected Health Information

FOLSOM CARDIOLOGY INC.

PRIVACY OFFICER: SARAH RICKEL

916-597-2687

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and California law, this practice may not use or disclose your individual Identifiable health information except as provided in our Notice of Privacy practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed.

Patient Name _____ Date of Birth _____ Acct# _____

Patient Address _____

Patient Phone _____

I authorize the following person(s) to receive my Protected Health Information (PMI).

Name of Person	Phone	Relationship

The information may be used only for the following purposes:

- ☐ At the request of the individual
- ☐ To provide information to family or friends
- ☐ Other: _____

I understand that I may revoke this authorization, in writing, at any time. My revocation will not affect actions taken by this medical practice prior to this receipt.

This authorization to use or disclose this protected health information is being submitted at my request and shall be in effect until revoked in writing by me.

I understand that I have the right to receive a copy of this information.

Signed: _____ Dated: _____

Print Name: _____

FOLSOM CARDIOLOGY

ePrescribing Consent Form

Folsom Cardiology Inc. is implementing ePrescribing in our office.

ePrescribing is a legally mandated initiative that requires all physicians prescribe in this manner.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information – like drug interactions and your prescription history.

The benefits to you:

- Less confusion over handwritten prescription or unclear phone calls.
- Reduced possibility of medicals errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

Patient Consent

I agree that Folsom Cardiology Inc. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purpose. I understand that the only previous prescriptions downloaded will be prescriptions that I obtained using an insurance card.

_____ _____

Patient Signature Date

_____

Patient Name

I do NOT permit Folsom Cardiology Inc. to download my information from Surescripts.

_____ _____

Patient Signature Date

_____

Patient Name