CAPITAL CARDIOLOGY

NEW PATIENT INFORMATION

DATE:_____

PATIENT NAME:_____

DATE OF BIRTH:_____**SS#**_____

ADDRESS:_____**APT.#**_____

CITY:_____**STATE:**_____**ZIP:**_____

HOME PHONE:( )_____**CELL PHONE:( )**_____

WORK PHONE ( ) _____**EXT.**_____

MARITAL STATUS: S M W D (Please circle) NAME OF SPOUSE:_____

PHARMACY NAME:_____**CITY:**_____

PRIMARY INSURANCE NAME:_____

SECONDARY INSURANCE NAME:_____

EMERGENCY CONTACT:_____

PHONE#:_____**RELATIONSHIP:**_____

CONSENT TO TREAT/FINANCIAL AGREEMENT

By my signature, I consent for treatment at Capital Cardiology. I understand that insurance co-pays are due at time of service. (Non-payment of co-pays is considered a breach of contract between you and your insurance company). I understand that I am responsible for any remaining charges not covered by my insurance company. I understand that if I am uninsured, payment is due at time of service.

Guarantor Signature:_____**Date:**_____

Capital Medical Group

PATIENT MEDICAL HISTORY

today's date: _____

Patient Name: _____ DOB _____

SOCIAL HISTORY

Birthplace		Education		Retired	
Occupation		Employer		Disabled	

Marital Status ____ Previously Widowed NO YES Previous Divorce NO YES # times ____

Children NO YES Sons ____ Daughters ____

TOBACCO YES NO Former Type ____ packs/day ____ yrs smoked ____ Yr quit ____

ALCOHOL YES NO Former Amount ____ Frequency ____ Last Drink ____ Yr quit ____

CAFFEINE YES NO Amount Daily ____

Changes in Sleep Pattern? YES NO Details: _____

HOME/SAFETY Smoke Detectors in Home? Yes / No Carbon Monoxide Detectors? Yes / No Fire Arms at Home? Yes / No Seat Belt Use Yes / No Home Heating Type: ____

Recent Travel out of state ____ out of country ____ COMMENTS: _____

Advanced Directive in Place? None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ Health Care Proxy? ☐

Past Medical: Please list past surgeries with date performed	List Current Medications:

FAMILY HISTORY

	Age	deceased ?	age at death		Age	deceased ?	age at death
Mother				Father			

Diagnosis: mark an "X" if you have the following — mark if Yes for your family member

	YES	NO	mother	father	brother	sister	other
ALZHEIMERS							
ASTHMA							
ALCOHOLISM							
BLOOD DISEASE							
CORONARY ARTERY DISEASE							
CANCER TYPE:							
DEPRESSION							
DEVELOPMENTAL DELAY							
DIABETES							
HEARING DEFICIENCY							
HIGH CHOLESTEROL							
HIGH BLOOD PRESSURE							
MENTAL ILLNESS							
TYPE:							
OBESITY							
POOR CIRCULATION							
KIDNEY FAILURE							
SEIZURE DISORDER							
SICKLE CELL DISEASE							
OTHER							

Capital Medical Group

Authorization Form to Get Records

PLEASE PRINT

Capital Medical Group is requesting records on _____
(Patient Name and DOB)
To authorize the use and disclosure of confidential healthcare information to:
Capital Medical Group
Address: _____
Phone#_____Fax#:_____ for the following purposes:

List and describe the purposes: _____
List the information that is to be used: _____
_____
_____

CONDITIONS:

- The patient agrees to authorize the above named individuals/organization to access his/her confidential healthcare information only for the purpose listed above.
- The information authorized to be released pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal law.
- The practice will provide the patient with a copy of the confidential healthcare information for which this authorization is being sought.
- The patient is voluntarily signing this authorization.
- The patient reserves the right to refuse to sign this authorization. Capital Family Physicians may not condition treatment, payment, or eligibility for benefits on whether the patient signs this authorization.
- The patient reserves the right to revoke this authorization at any time. This revocation must be in writing.
- The patient will receive a copy of the signed authorization.
- The authorization will be maintained by Capital Family Physicians, P.S.C. for a period of six (6) years.
- This authorization is in effect from _____ to _____ (length of time). Upon the conclusion of that time period, this authorization is automatically revoked and no further use of the patient's confidential healthcare information is permitted beyond that date.

SIGNATURES:

Patient/Legal Representative:_____ Date: _____

Medical Records Representative: _____ Date: _____

Authorization Form to Send Records

PLEASE PRINT

_____is authorizing the use and disclosure of confidential
(Patient Name and DOB)
Healthcare information be sent from Capital Medical Group to:
Name: _____
Address: _____
Phone#_____Fax#:_____ for the following purposes:

List and describe the purposes: _____
List the information that is to be used: _____
_____
_____

CONDITIONS:

- The patient agrees to authorize the above named individuals/organization to access his/her confidential healthcare information only for the purpose listed above.
- The information authorized to be released pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal law.
- The practice will provide the patient with a copy of the confidential healthcare information for which this authorization is being sought.
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- This authorization is in effect from _____ to _____ (length of time). Upon the conclusion of that time period, this authorization is automatically revoked and no further use of the patient's confidential healthcare information is permitted beyond that date.

SIGNATURES:

Patient/Legal Representative:_____ Date: _____

Medical Records Representative: _____ Date: _____

AUTHORIZATION/RESTRICTION AGREEMENT
RELEASE OF PATIENT INFORMATION CONSENT FORM

PATIENT NAME:_____ DOB:_____

Release information to:_____

_____

Reason for Release: _____

The information authorized to be released pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal law. Capital Family Physicians may not condition treatment, payment or eligibility for benefits on whether the patient signs this authorization.

Please Initial:

_____ I hereby authorize Capital Medical Group, to provide the above-named individual or company with the medical data and information they may request, as listed below, concerning my illness or injury.

_____ I hereby authorize Capital Medical Group to provide the above-named individual or company with specific elements of my medical data and information as designated below, concerning my illness or injury.

_____ I hereby refuse Capital Medical Group to provide the above-named individual or company with the medical data and information concerning my illness or injury.

MEDICAL DATA / INFORMATION

_____ Name, Address, Phone Number

_____ Social Security Number

_____ Date of Office Visit

_____ Diagnosis

_____ Findings of Examination

_____ Laboratory Data

_____ Reports of Diagnostic Tests

_____ Reports of Surgical procedures

_____ Listing of Medications

_____ Listing of Treatments

_____ Information from Physician Consults

_____ Billing Information

_____ Verification of Scheduled Appointments

_____ Ancillary personnel notes (check all those that apply)
_____ Nursing _____ Social Services _____ Pharmacy _____ Dietary
_____ Psychiatric Services

Signature of Patient or Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

(Original to be placed in patient's medical record)