Welcome to Cardiology, PC. We look forward to meeting you. Please make sure to arrive 20 minutes prior to your scheduled appointment time to allow our staff enough time to register you before your visit with our physician. Please feel free to visit our website at www.cardiologypcofhartford.com.

You have been scheduled to see one of our physicians in one of our three locations: Hartford, Farmington or Manchester. Included in this letter is information that will assist you and our staff in the registration process. **In the event that you cannot keep your appointment, please give the office a minimum of 24-hour notice. Failure to notify our office will result in you being assessed a $30.00 no show fee in accordance with our No-Show Policy.**

The following forms are enclosed:

1. **Patient Registration Form –** Please review and complete this form in its **entirety**. Please mail it back to our office in the enclosed envelope or fax it to 860.520.4270. Even if you have given this information orally the form **MUST** be completed.
2. **Patient Health History Form –** Complete this form in its **entirety**. Please mail it back in the enclosed envelope or fax it to 860.520.4270. This form will be reviewed by the Physician and discussed at your appointment.
3. **Notice of Privacy Practices –** Upon arrival at our office, at your request, you will be provided with our Notice of Privacy Practices.
4. **Insurance Cards, Photo ID, Copay & Financial Policy –** You will need to bring any and all insurance card(s) and be prepared to pay your Copay, when applicable, upon arrival for your appointment. You also are required to provide a photo ID at each visit with our office. Our financial policy is enclosed for your review.
5. **Medicare Patients –** If you or your spouse are employed and have Medicare, please confirm with Medicare before your appointment which insurance is primary. Failure to do so could result in your claim being denied. In this scenario the balance due would become the patients' responsibility.
6. **Referral –** If your insurance requires a referral to see a specialist, it is your responsibility to contact your primary care physician and have them process this request for you. Most offices require a 48-hour notice. If your referral is not in place on the day of your appointment, you will either need to reschedule your visit or sign a waiver stating you will be responsible for the balance. Should you sign a waiver you still will need to contact your PCP regarding the referral. When the referral is received the waiver will be **destroyed** and your insurance company will be billed appropriately.
7. **Appointment Card –** please find this card enclosed confirming the date, time and location of your appointment as well as directions to our office.
8. **EKG –** you can expect to have an EKG at your appointment. Please **do not** wear any lotions or creams as they may interfere with the leads sticking and could cause an inaccurate reading.
9. **Medication list –** please bring an up to date list of **all** medications including the dose and prescribing provider.
10. **Stress Test –** additional instructions and guidelines have been included if you have been scheduled for this study. This will allow you to be prepared when you arrive.

If we can be of any further assistance, please do not hesitate to contact our office. Our New Patient Coordinator can be reached at 860.522.5712 x131.

Cardiology, PC
Enclosures

ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES &
CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ Date of Birth: _______________________

1. **I have been offered or received a copy of Cardiology PC's "Notice of Privacy Practices"**

   Patient Signature: ____ Date: ______________________________

2. **I give permission for Cardiology PC to contact me at the following numbers and to leave messages on voicemail"**
   MESSAGES CONCERNING APPOINTMENTS: Phone: ______________________________________
   Please Circle: Home/ Mobile/ Work

   MESSAGES CONCERNING TEST RESULTS: Phone: _______________________________________
   (i.e. lab or test results) Please Circle: Home/ Mobile/ Work

3. **I give my permission for Cardiology PC to communicate with the following individual(s) regarding my healthcare:**

   Name: _______________________________ Phone: _______________________ Relationship: ________________

   Name: _______________________________ Phone: _______________________ Relationship: ________________

This authorization will be valid from this date until written notice of changes and/or cancellation is received in the offices of Cardiology PC

Are there any other Providers other than your Primary Care Provider that you would like to receive our information including office notes, testing, and other results associated with your care?

Primary Care Provider: ____________________________________ Address: _________________________Phone: ____________

Name/Specialty: ____ Address: _________________________ Phone: ____________

Name/Specialty: ____ Address: _________________________ Phone: ____________

Name/Specialty: ____ Address: _________________________ Phone: ___________

CARDIOLOGY P.C.

CARDIOLOGY PC REGISTRATION FORM

Name: Date of Birth: Social Security #
Address: City: State: Zip:

Marital Status (please circle one): Single Married Widowed Divorced Domestic Partner Other ________
Male _____ Female _____ Email:
Home Phone: Work Phone: Mobile Phone:
Language: Race: Ethnicity:

Employer Name & Address:
Emergency Contact: Relationship: Contact Number:

Primary Insurance:			
Identification #:	Group/Policy #:		
Name of Policy Holder:			
Policy Holder DOB:	Social Security #: - -	Employer:	
If you have Medicare, are you or your spouse employed? Yes	*No*		
If Medicare is secondary – Check Reason	*You/Spouse Working*	*Disabled*	*ESRD Other*

Secondary Insurance:			
Identification #:	Group/Policy #:		
Name of Policy Holder:	Relationship to Patient:		
Policy Holder Information:	DOB:	Social Security #: - -	Employer:

Third Insurance (if applicable):	ID #:	Group #:
Name of Policy Holder (If not patient)	Relation to Patient:	

IS THIS VISIT A WORKERS COMP CASE? ____________YES ______________ NO

Referring Physician: ____ Primary Care Provider: ______________________________

Pharmacy: _______________________________ Phone: _________________ Mail Order Pharmacy (if applicable): ____________

Preferred Lab: ____________________________ City: ____________________ Phone: ___________________________

1. I have reviewed the foregoing information and affirm that it is correct. I hereby authorize Cardiology PC to furnish information concerning my health to my insurance carrier, other physicians, or healthcare facilities involved in my care and hereby assign to Cardiology PC all insurance payments for services rendered to myself. I further accept responsibility for payments due according to my healthcare contract, including but not limited to, deductibles, co-pays, and co-insurance.

   Patient Signature: ___________________________ **Date:** _______________

2. I hereby authorize Cardiology PC to obtain electronic information concerning my prescription history from my pharmacy benefits manager.

   Patient Signature: ___________________________ **Date:** ________________

3. I DO NOT authorize Cardiology PC to obtain electronic information concerning my prescription history:

   Patient Signature: ___________________________ **Date:** ________________

PATIENT HEALTH HISTORY FORM - CARDIOLOGY, PC

Please fill out the following information about yourself. This will be kept as part of your medical record.

Name: ___________________________________ DOB: ___________________________ Today's Date: ___________________

Reason for visit: ____

PAST MEDICAL HISTORY: Circle Yes or No

Aortic Aneurysm Y / N	Deep Vein Thrombosis Y / N	Neurologic Disease Y / N
Arrhythmia: Atrial fibrillation/flutter Y /N	Diabetes Y / N	Pericarditis Y / N
Supraventricular Tachycardia Y /N	Endocarditis Y / N	Peripheral Vascular Disease Y / N
Wolff-Parkinson-White Syndrome Y / N	Gastrointestinal Disease Y / N	Post-Menopausal Y / N Age:
Arrhythmia Ventricular Y / N	Genitourinary Disease Y / N	Prostate Disease Y / N
Bradycardia Y / N	Heart Valve Disorder Y / N	Psychiatric Illness Y / N
Bundle Branch Block Y / N	Hematologic Disease Y / N	Pulmonary Disease Y / N
Asthma Y / N	Hyperlipidemia (Cholesterol) Y / N	Pulmonary Embolism Y / N
Cancer Y / N	Hypertension (Blood Pressure) Y / N	Pulmonary Fibrosis Y / N
Cardiomyopathy Y / N	Infectious Disease Y / N	Pulmonary Hypertension Y / N
Cerebral Vascular Accident (or TIA) Y / N	Kidney Disease Y / N	Reynaud's Disease Y / N
Chronic Infections Y / N	Liver Disease Y / N	Rheumatic Heart Disease Y / N
Chronic Obstructive Disease Y / N	Marfan's Disease Y / N	Rheumatologic Disease Y / N
Congenital Heart Disease Y / N	Musculoskeletal Disorder Y / N	Sleep Apnea Y / N
Congestive Heart Failure Y / N	Myocardial Infarction Y / N	Syncope/Fainting Y / N
Coronary Artery Disease Y / N	Myocarditis Y / N	Thyroid Disease Y / N
Other:	Other:	Other:
If you have had any of the procedures below please indicate the date and location they were performed:		
Cardiac Catheterization:		
Echocardiogram (Heart Ultrasound):		
Exercise Stress Test:		

PAST SURGICAL HISTORY: Procedure date and hospital

____

____

____

____

PAST HOSPITALIZATIONS: Reason, date & hospital

____

____

CURRENT MEDICATIONS: Name/dosage/frequency prescribing provider

Name	Dosage	Frequency	Prescriber

MEDICATION ALLERGIES & REACTIONS:

____

____

CARDIOLOGY P.C.

SOCIAL HISTORY: Please check all that apply

Marital Status:	Single _____	Married _____	Separated _____	Divorced_____	Widowed _____	Domestic Partner _____
Children:	No _____	Yes (number / ages): ______________________________				
Caffeine Use:	None _____	Cups/Day _____				
Alcohol Use:	None _____	Rare _____	Moderate _____	Frequent _____	Prior _____	Drinks/Week _____
Tobacco Use:	Never _____	Prior (quit date) _______		Current ______	Packs/Day _________	
Substance Use:	Never _____	Prior (quit date) ________		Current (type) ______________________		
Exercise:	No _____	Yes _____	Rare ______	Moderate _____	Avid _____	Hours/Week _____
Employed:	Yes _____	No _____	Occupation: ______________________________			

FAMILY MEDICAL HISTORY: Please circle all diagnosis that apply
Father (F), Mother (M), Brother (B), Sister (S), Children (C), Age at onset

Aneurysm	Relation	Age	Diabetes	Relation	Age			
Arrhythmia	Relation	Age	Heart Attack	Relation	Age	Stroke (or TIA)	Relation	Age
Blood Clots	Relation	Age	Hypertension	Relation	Age	Sudden Cardiac Death	Relation	Age
Congenital Heart Disease	Relation	Age	High Cholesterol	Relation	Age	Vascular Disease	Relation	Age
Coronary Artery Disease	Relation	Age	Kidney Disease	Relation	Age			

Other: ____

REVIEW OF SYSTEMS: Please circle if you are experiencing any of the following:
Constitutional: fever, chills, night sweats, weight gain (__) , weight loss (__), exercise intolerance, fall asleep during the day

Eyes, Ears, Nose, Mouth, Throat: loss of vision, vision changes, double vision, dry eyes, difficulty hearing, ringing in ears, ear pain, nosebleeds, nose/sinus problems, teeth problems, throat problems, gum problems, snoring

Cardiovascular: chest pain, chest pain on exertion, arm pain on exertion, short of breath when walking, short of breath when lying down, palpitations, heart murmur, swelling in legs/feet, lightheaded when standing, pain in legs with exercise/walking

Respiratory: cough, wheeze, short of breath at rest, pain with deep breath, coughing up blood

Gastrointestinal: abdominal pain, vomiting, change in appetite (increase / decrease), change in bowel habits, black or tarry bowel movements, blood in stools, frequent diarrhea, vomiting blood, constipation

Genitourinary: loss of control, difficulty urinating, blood in urine, increased frequency, painful urination, erectile dysfunction, Menstrual problems, last menstrual period – date: ______________________

Musculoskeletal: muscle pain, muscle weakness, joint pain, back pain

Skin: yellowing of skin (jaundice), abnormal mole(s), rash, itching, dry skin, growths/lesions

Neurologic: memory loss, loss of consciousness, weakness, numbness, seizures, dizziness, headaches, migraines, tremors, falling episodes

Psychiatric: depression, sleep disturbances, anxiety, restless sleep, feeling unsafe in relationship, alcohol/substance abuse

Endocrine: fatigue, increased thirst, hair loss, increased hair growth, cold intolerance, heat intolerance

Hematologic: swollen glands, easy bruising, excessive bleeding

Allergic/Immunologic: seasonal allergies, medication allergies, hives, upper respiratory congestion

To the best of my knowledge, I have answered all questions on this form accurately. I understand that providing incorrect information may be dangerous to my health. It is my responsibility to inform my doctors of any changes in my medical status.

_______________________________________ _______________________________________
Signature of Patient Date Signature of Physician/APRN Date