

**• PATIENT INFORMATION FORM •**

**PLEASE PRINT CLEARLY**

Today's Date:

Name:

Date of Birth:

Address:

Your age:

Gender:

City:

Marital Status:

State:

Zip:

Email Address:

Employer:

Your occupation:

Do you have a living will?:  Yes  No

**YOUR CONTACT INFORMATION**

Home Phone:

Cell:

Work:

Do you give permission to Abington Medical Specialists to leave messages on your answering machine or voicemail?

Yes  No If yes, which phone no.:  Home  Cell  Work

Which number do you prefer to be contacted on:  Home  Cell  Work

**Please note:** New Healthcare regulations require us to obtain the following information:

Ethnicity:

Caucasian

African American

Hispanic

Language Spoken:  English  Korean

American Indian

Native Hawaiian

Hindi  Spanish

Asian

Other Pacific Islander

If other language, please specify:

Other Ethnicity:

Do you require a foreign language interpreter present at your appointment with our doctor?  Yes  No

**EMERGENCY CONTACT INFO**

I give permission for Abington Medical Specialists (AMS) to discuss my healthcare with the following person(s):

1) Name:

Phone:

Relationship:

2) Name:

Phone:

Relationship:

**FAMILY PHYSICIAN & PHARMACY INFORMATION**

Name:

Phone:

Address:

City:

State:

Zip:

Your Pharmacy Name:

Phone:

Who referred you to AMS Cardiology:

**INSURANCE INFORMATION**

Insurance Company:

Policy No:

Group No:

Insurance Address:

Subscriber's Name:

Subscriber's DOB:

Subscriber's Employer:

Phone:

Your relationship to Subscriber:  Self  Spouse  Parent  Other (specify)

I acknowledge that I received or was offered a copy of the AMS Privacy Act (HIPAA):  Initials

<<< Please also complete the reverse side of this form >>>

version 2.6

**AUTHORIZATIONS**

**ALL NEW AMS PATIENTS FILL OUT THIS SECTION:**

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or to another physician's office.

I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance, and any other health plan to Abington Medical Specialists.

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges, whether or not paid by insurance.

\*

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

**MEDICARE PATIENTS ONLY, FILL OUT THIS SECTION:**

I request that payment of authorized Medicare benefits be made to me or on my behalf to Abington Medical Specialists for any services furnished to me by Abington Medical Specialists. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

\*

\_\_\_\_\_  
Signature of Medicare Patient

\_\_\_\_\_  
Date

I request that payment of authorized Medicare Supplemental benefits be made to either me or on my behalf to Abington Medical Specialists for any services furnished me by that physician/supplier. I authorize any holder of Medicare information about me to release to \_\_\_\_\_ any information needed to determine these benefits payable for related services.

\*

\_\_\_\_\_  
Medicare Beneficiary Signature

\_\_\_\_\_  
Date

**In compliance with Medicare regulation, we ask that you answer the following questions:**

Do you or your spouse work for a company that provides you with health insurance?      \_\_\_ yes    \_\_\_ no

Are you entitled to Medicare because of disability or End Stage Renal Disease?      \_\_\_ yes    \_\_\_ no

Is the illness or injury the result of an automobile accident or other injury?      \_\_\_ yes    \_\_\_ no

Has treatment for the accident or illness been authorized by the Veteran's Administration?      \_\_\_ yes    \_\_\_ no

Are you entitled to any benefits under the Federal Black Lung Program?      \_\_\_ yes    \_\_\_ no

I certify that this information is true and complete to the best of my knowledge.      \_\_\_ yes    \_\_\_ no

\*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# CARDIOVASCULAR HEALTH QUESTIONNAIRE

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Smoking History: \_\_\_\_\_

Occupation: \_\_\_\_\_

Drug Allergies: (list medications and symptoms caused): \_\_\_\_\_

**Please list current medications, including any vitamins & supplements:**

**Previous Surgery: (list operations and dates)**


Family History:	Living	Deceased	Cause of Death	Illnesses
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

Do you have any of the following?	Yes	No	If yes, for how long?
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Chest Pain: ____ at rest or ____ with exercise	_____	_____	_____
Shortness of Breath	_____	_____	_____
Diabetes (or abnormal blood sugar)	_____	_____	_____
Increased or abnormal blood pressure	_____	_____	_____
Swelling of the Legs or Feet	_____	_____	_____
Pain in the Calves when Walking	_____	_____	_____
Heart Murmur	_____	_____	_____
History of Rheumatic Fever	_____	_____	_____
Palpitations (skipped heart beats or "rapid heart action")	_____	_____	_____
Passing out or Black-out Spells	_____	_____	_____
Have you ever had a "Heart Attack"?	_____	_____	_____
Have you ever been told you had an "Abnormal EKG"?	_____	_____	_____
History of Lung Disease	_____	_____	_____
History of Bleeding Disorder or Internal Bleeding	_____	_____	_____

Do you have an inserted device like an ICD, pacemaker or defibrillator? If so, please indicate brand:

_____ St. Jude	_____ Medtronic
_____ Boston Scientific	_____ Biotronic

Other (or unknown): \_\_\_\_\_

What single complaint bothers you the most?  
 (Please use reverse side or below if more room is needed) \_\_\_\_\_