• 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)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

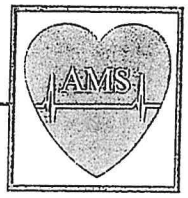
Family History:	Living	Deceased	Cause of Death	Illnesses
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

Do you have any of the following?	**Yes**	**No**	**If yes, for how long?**
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) _____



Record Request Form from AMS Cardiology

Medical Record Fax Line: 215-376-1705

Please Print:

I, _____
(patient name)

hereby request that _____
(name of doctor)

send copies of the following records pertaining to my health care:

(**Important:** please initial the line in front of each item you would like to be sent*)

_____ 1. Office notes and related reports including any hospital summaries / data

_____ 2. Communications in my records from other physicians, including consultants.

_____ 3. List any specific items to be sent that are not covered by items 1 & 2:

_____

_____

List any items that should NOT be sent, if applicable: _____

_____

Send Records to: _____

_____

_____

Or Fax to: _____ Attn: _____

Your Signature: _____

PRINT NAME: _____

Date of Birth: _____

Date of Request: _____

*without initials, only data included in item #1 will be sent