New Patient History Form

Name: _____ Age: _____ Sex: M F Race: W / AA / H / A / Other: _____

Present complaints or symptoms (list separately):

_____
_____
_____
_____
_____
_____

Review of Symptoms (circle all that apply):

Systemic
fever
weight loss/gain____lbs
fatigue
appetite increase/decrease

HEENT
headache
sinus
ringing of ears
snoring
excess sleepiness

GI
heartburn
stomach pain
bowel changes
cancer
liver problems
gallbladder

Cholesterol
Total _____, LDL_____,
HDL_____, TG_____

GU
sexual dysfunction
urinary tract infection
urinary complaints
kidney stones
prostate problems
vaginal discharge
menstrual changes

Pulmo
cough
shortness of breath
wheezing

Muscle/JT
joint pain
muscle aches
weakness
backache
mouth sores

CNS(Brain & NS)
dizziness
numbness/weakness
in extremities
sleep problems

Endocrine
thyroid problems

Blood
anemia
lymph node swelling
bleeding tendency

CVS
chest pain resting or during exertion
heart palpitations
calf pains

Past Medical History

Heart Attack_____
Heart Failure_____
Diabetes_____
Hypertension_____
Emphysema/Asthma _____

Rheumatic Fever_____
Arthritis_____
Bleeding Ulcer_____
Peptic Ulcer/Hiatal Hernia_____
Other _____

Prior Hospitalization and/or Surgeries:

Cardiac Catheterization or Angiogram: Yes / No When:_____
Any problems with procedure?_____nphxform.doc
Hysterectomy: Yes / No Year:_____

***PLEASE COMPLETE BOTH SIDES OF THIS FORM ***

CAROLINA HEART CENTER
NEW PATIENT HISTORY FORM PAGE 2

Name:_____

SOCIAL HISTORY:

	How many years?	How much a day?	If quit when?
1. Smoking:	_____	_____	_____
2. Alcohol:	_____	_____	_____
3. Other Drugs:	_____	_____	_____

(Cocaine, Marijuana, Intravenous)

OCCUPATION:

1. Present:_____
2. Past:_____

FAMILY HISTORY: (at what age did heart condition start)

Father	MI / PTCA / CABG	Age_____	Diabetes _____
Mother	MI / PTCA / CABG	Age_____	High Cholesterol_____
Brother/Sister	MI / PTCA / CABG	Age_____	Cancer_____
Brother/Sister	MI / PTCA / CABG	Age_____	Thyroid_____
_____	MI / PTCA / CABG	Age_____	Rheumatoid Arthritis _____
_____	MI / PTCA / CABG	Age_____	Lupus_____

Are you allergic to any:

Medications_____
Shrimp or Seafood_____
IVP Dye_____
Latex _____

MEDICATIONS:

Please list all medications below (prescription AND over-the-counter)

Name	**Dose & Interval**	Who Prescribed

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

CURRENT PHYSICIANS:

Physician:	Telephone	Date Last Seen
_____		
_____		
_____		
_____		

CAROLINA HEART CENTER, P.A.
Pankaj N. Parikh, MD
3406 Six Forks Road
Raleigh, NC 27609
919-881-7770

PATIENT INFORMATION

Name: _____
LAST FIRST MIDDLE

Address: _____ City _____ State ___ Zip _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Ext _____

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____ Sex: M F

Marital Status: _____ In Case of Emergency: _____
Contact Person Phone Number

My E-Mail Address: _____@_____

INSURANCE INFORMATION: Primary _____

Secondary _____ Tertiary _____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment to Carolina Heart Center, P.A. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

CREDIT POLICY:
For services rendered, a claim will be filed with your insurance carrier. HOWEVER, ALL DEDUCTABLES, CO-PAYS, AND PERCENTAGES ARE TO BE PAID ON THE SAME DAY SERVICES ARE RENDERED. We accept cash, check, MasterCard and VISA. You will be notified when final action by your insurance carrier has been received. If any funds are due, payment will be expected within thirty-days of receipt of that notice.

AUTHORIZATION FOR RELEASE OF INFORMATION:
I hereby authorize Carolina Heart Center, P.A. to release any medical or incidental information that may be necessary for either medical care or in processing of claims for financial benefits. Carolina Heart Center, PA is authorized to release my protected health information to my spouse and/or other family members as needed. Unless specified, I may be contacted at my home/work/cell-phone or any telephone number provided. I understand I have the right to revoke this authorization at any time.

PATIENT PRIVACY POLICY:
I have received and/or read a copy of the Notices of Privacy Practices for Carolina Heart Center, P.A.

I HAVE READ AND UNDERSTAND THE TERMS AND POLICIES AS STATED ABOVE.

_____ _____
PATIENT'S SIGNATURE (or legal guardian) Date