CAROLINA HEART CENTER, P.A.
New Patient History Form

Name: ___________________________ Age: ________ Sex: M F Race: W / AA / H / A / Other: ______

Preferred Pharmacy _________________Pharmacy Phone# _____________ Zip-Code:________

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
snoring
excess sleepiness

GI
heartburn
stomach pain
Nausea/Vomiting
gallbladder disease
liver problems

Cholesterol
Total _______, LDL______,
HDL _______, TG _______

GU
sexual dysfunction
prostate problems
urinary complaints
kidney stones

Pulmo
cough
shortness of breath
wheezing

Muscle/JT
joint pain
muscle aches
weakness
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

Any other symptoms: ____

Past Medical History

Heart Attack______________
Heart Failure______________
Diabetes__________________
Hypertension______________
Emphysema/Asthma ______

Rheumatic Fever_________________
Arthritis_________________________
Peptic Ulcer/Hiatal Hernia__________
Other __________________________

Prior Hospitalization and/or Surgeries:

Cardiac Catheterization or Angiogram: Yes / No When:____________________
Any problems with procedure?____

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:

(**MI =** heart attack**; PTCA =** coronary artery bypass operation)

(**CABG =** carotid artery bypass; **A**ge = age at time it occurred)

Father	MI / PTCA / CABG	Age______
Mother	MI / PTCA / CABG	Age______
Brother/Sister	MI / PTCA / CABG	Age______
Brother/Sister	MI / PTCA / CABG	Age______
___________	MI / PTCA / CABG	Age______
___________	MI / PTCA / CABG	Age______

Condition	**Family Members Affected**
High Blood Pressure	________________
Diabetes	________________
High Cholesterol	________________
Cancer	________________
Thyroid	________________
Rheumatoid Arthritis	________________
Lupus	________________

Are you allergic to any:

Medications____

Shrimp or Seafood____

IVP Dye____

Latex ______________________________Others: ___________________________

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

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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: (_____) ____________________ Cell Phone: (_____) ___________________ Ext ________

Work Phone: (_____) ___________________ Ext ________ Other: (_____) _________________________

Date of Birth: _______/_______/_______ Social Security # _________-______-_________ Sex: M F

Marital Status: ___________________ In Case of Emergency: ____________________(___)_______________
Contact Person **Phone Number**

My E-Mail Address: _________________@______________

INSURANCE INFORMATION: Policy Holder:______________________________; His/Her DOB:________

Primary Ins.____________________________________ Policy Number: ______________________________

Secondary Ins.__________________________________ Policy Number: ______________________________

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 DEDUCTIBLES, 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**