MONTCLAIR
CARDIOLOGY GROUP

# HUMG-C Montclair Cardiology Group

## Patient Information

Patient's Last Name: ______ First Name: ______ Date: ______
Street Address: ______ Apt. # ______ City: ______ State: ______ Zip: ______
Home Phone # ( ) - Work Phone # ( ) - Ext. ______
Cell Phone # ( ) - Email: ______
Social Security # ______ Date of Birth: / / Age: ______
Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Divorced
Reason for Visit: ______
Emergency Contact: ______ Relationship ______ Telephone # ( ) -
Pharmacy Name: ______ City: ______ Telephone # ( ) -
How did you hear about our Practice? ______
Due to government regulations, this is a requirement. However, you have the option to refuse.
Ethnicity: ______ Race: ☐ White ☐ African American ☐ Asian ☐ Hispanic ☐ Other
Language: ______ Refused: ☐

## Employer Information

Name of Employer: ______ Telephone # ( ) -
May we contact you at work? ☐ Yes ☐ No

## Primary Insurance

Primary Insurance Name: ______ Telephone # ( ) -
Address: ______ City: ______ State: ______ Zip: ______
Policy # ______ Group # ______ Effective Date: / /
Co-pay $ ______ Name of Insured: ______ Insured SS# ______
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ______
Insured Date of Birth: / /

## Patient Privacy

In order to protect your privacy and in accordance with Federal law, we do not leave confidential medical information on answering machines or with anyone other than the patient's legal guardian.

**Please indicate below your preferences:**

☐ We may leave detailed messages on this answering machine # ( ) -
☐ Do not leave detailed messages on any answering machine
☐ You may leave messages with this/these:
Person/People ______ Telephone # ( ) -

1. I authorized the release of any medical information necessary to process my insurance claim(s) to

Millennium Practice Management Associates, Inc.

2. I authorize and request payment of medical benefits directly to my physician(s) at HUMG-CP,
3. I agree that a photocopy of this form may be used in lieu of the original
4. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles, co-payments, co-insurance and non-covered services.

x______________________________________ [ ] / [ ] / [ ]

Patient/Authorized Signature Date

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# Comprehensive Patient History

Patient Name: ________________________________ Date of Birth: ___________ Today's Date __________

Please describe the problem you would like the doctor to address at today's visit:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

How long have you had this problem? _______________ Location: ______________________
How severe is this problem? Mild ____ Moderate ____ Severe ____
How often is this problem occurring? _________________
What caused this problem? ______________________
Do you know of anything else that may have contributed to this problem? _______________________
Does anything else occur with this problem? _______________________________________________

Please list hospitalizations/surgeries/serious injuries, and when they occurred:

____________________________________________
____________________________________________
____________________________________________
____________________________________________

Please list all medications with dosages:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

**Patient Social History**

Marital status: ___ Single ___ Married ___ Divorced ___ Widowed
Use of alcohol: ___ Never ___ Rarely ___ Moderate ___ Daily
Use of tobacco: ___ Never ___ Previously but quit (date) __________
Caffeine intake: ___ Never ___ Type/Frequency __________________________________________________
Do you exercise? Describe _______________________________________________________________
Are you on a special diet? (Y/N) Describe _______________________________________________________
______________________________________________________________________________

**Allergies**

Do you have any drug allergies? (Y/N) __________________________________________________________
Any other allergies (Y/N) If yes, please explain ____________________________________________________

**Have you ever had the following?** (please circle)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Attack | yes | no | Hypertension | yes | no | Asthma | yes | no |
| Abnormal EKG | yes | no | Elevated Cholestrerol | yes | no | Lung Disease | yes | no |
| Congestive Heart Failure | yes | no | Vascular Surgery | yes | no | Stroke/TIA | yes | no |
| Seizure Disorder | yes | no | Heart Valve Problem | yes | no | Thyroid Disease | yes | no |
| Diabetes | yes | no | Rheumatic/Scarlet fever | yes | no | Malignancy (type) _______________ | | |
| Gout | yes | no | Migraine | yes | no | GERD | yes | no |
| Ear/Nose/Throat Disorder | yes | no | Major Surgery (type) ___________ | | | Colitis | yes | no |
| Peptic Ulcer | yes | no | Eye Disorder (type) ____________ | | | | | |
| Gallstones | yes | no | Heart Rhythm Abnormality | yes | no | | | |

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**Is there a family history of the following?** (please circle)

| | | | | | |
|---|---|---|---|---|---|
| Heart Disease | yes | no | Hypertension | yes | no |
| Cancer | yes | no | Diabetes | yes | no |
| Stroke | yes | no | | | |

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**Have you personally experienced any of the following?** (please circle)

| | | |
|---|---|---|
| **Constitutional** | | |
| Recent weight loss or gain | yes | no |
| Fever/Sweats | yes | no |
| Fatigue | yes | no |
| **Eyes** | | |
| Blurred or double vision | yes | no |
| Diminished visual acuity | yes | no |
| Eye pain | yes | no |
| **ENT** | | |
| Hearing loss | yes | no |
| Hoarseness | yes | no |
| Ear pain | yes | no |
| Ringing in the ears | yes | no |
| **Cardiovascular** | | |
| Chest pain/pressure | yes | no |
| Palpitations/fluttering of the heart | yes | no |
| Swelling of legs/feet | yes | no |
| **Respiratory** | | |
| Cough | yes | no |
| Sputum/wheezing | yes | no |
| Shortness of breath | yes | no |
| Pain with inspiration | yes | no |
| **Skin** | | |
| Rash or itching | yes | no |
| **Gastrointestinal** | | |
| Abdominal pain | yes | no |
| Problem swallowing | yes | no |
| Decreased appetite | yes | no |
| Nausea/vomiting | yes | no |
| Diarrhea | yes | no |
| Constipation | yes | no |
| **Genitourinary** | | |
| Frequent urination | yes | no |
| Painful urination | yes | no |
| Sexual dysfunction | yes | no |
| **Musculoskeletal** | | |
| Joint pain/stiffness | yes | no |
| Pain in legs or buttocks while walking | yes | no |
| **Neurological** | | |
| Headaches | yes | no |
| Sleep problems | yes | no |
| Fainting or blackouts | yes | no |
| Dizziness | yes | no |
| Balance difficulty | yes | no |
| **Endocrine** | | |
| Cold intolerance | yes | no |
| Heat intolerance | yes | no |
| **Psychiatric** | | |
| Anxiety | yes | no |
| Depression | yes | no |

**Have you ever had the following tests:**

_____ Stress Test Date: ___________________
_____ Coronary Angiogram/Cardiac Catheterization Date: ___________________
_____ Echocardiogram Date: ___________________
_____ Holter Monitor Date: ___________________

_____ History was filled out by other than patient. Print name and relationship: _____________________________________

Patient Signature: _____________________________________

## ASSURANCE OF PRIVACY FOR OUR PATIENTS

**To Our Valued Patient:**

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule" . We strive to achieve the very highest standard of ethics and integrity, when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We realize there is always room for improvement! It is our policy to listen to our employees and our patients. If you feel your privacy has been compromised in any way, please ask to speak with our compliance officer or express your concern to your physician.

Please read the following "Notice of Privacy". After reading, sign and return this form to the receptionist. If you have any questions, please ask. Thank You.

### NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information (PHI) is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing patient health information that is needed to carry out proper treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum amount of necessary information to only those who we feel are in need of your health care information. **We strive to provide the best health care that is in your best interest**

We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties you do not want PHI released to please tell our compliance officer and it will be documented in your chart. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our compliance officer. You have the right to review our entire privacy policy manual upon request. Please sign this form to acknowledge that you have read this patient notice of privacy.

Patient Name: ____________________________________________

Signature: ____________________________________________

If minor, signature of parent/guardian: ______________________________

**THANK YOU FOR BEING ONE OF OUR HIGHLY VALUED PATIENTS.**

***FOR OFFICE USE ONLY***

A "good faith effort" was made to get a signature from patient, guardian, and caretaker. Signature was not attained due to the following: