

SPACE COAST CARDIOLOGY CONSULTANTS, P.A.

Name: _____ **Date:** _____
First Middle Initial Last

Birth Date: ____/____/____ **Sex:** M ____ F ____ **Race:** B ____ W ____ H ____ **Other:** ____

Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Number: _____

Employer: _____ Work Phone Number: _____

Primary Care Physician: _____

Referring Physician: _____

Marital Status: ____ Married ____ Single ____ Widowed ____ Divorced

Spouse's Name: _____ Work Phone: _____

*******INSURANCE INFORMATION*******

Primary Insurance: _____

Is the policy in your name? Yes No If No, Who is the policy holder? _____

Policy holder's DOB: ____/____/____ Policy holder's SS#: _____

Employer: _____

Secondary Insurance: _____ Is the policy in your name? Yes No

If No, who is the policy holder? _____

Policy holder's DOB: ____/____/____ Policy holder's SS#: _____

Employer: _____

Do you have a Living Will? Yes No

Who should we contact in case of an Emergency (Other than your spouse)?

Name Phone # Relationship to Patient

SPACE COAST CARDIOLOGY CONSULTANTS, P.A.
PATIENT HEALTH HISTORY

Name: _____ Date: _____

Age: _____ Referring Physician: _____

Have you ever had any of the following illnesses or symptoms? Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Dizziness/Lightheadedness | <input type="checkbox"/> Convulsions/Seizures |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gout |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Irregular Pulse | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Leg Edema/Swelling | <input type="checkbox"/> Leg Pains |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Leg Pains with Walking |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Prior Heart Attack/Heart Failure | <input type="checkbox"/> Hemophilia/Bleeding Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Asbestosis | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Fluid in Lungs | <input type="checkbox"/> Interrupted Urination |
| <input type="checkbox"/> Thyroid Illness | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Cancer – Specify Type: _____ | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Other: _____ |

Please list known **Allergies** to Medications: _____

Please list **All Medications** you are currently taking, dosages and frequency: _____

Please list **Major Health Problems of Family Members** such as Diabetes, Heart Disease, High Blood Pressure, etc.: _____

Please list all **Surgeries** including Heart Catheterizations or Pacemakers: _____

Do you smoke? _____ How Much? _____

Do you drink Alcohol? _____ How Much? _____

Do you drink coffee or tea? _____ How Much? _____

Have you ever seen a Cardiologist Before? _____ Reason: _____

SPACE COAST CARDIOLOGY CONSULTANTS, P.A.

**AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL
INFORMATION**

I hereby give my consent to Space Coast Cardiology Consultants to provide Medical treatment to myself.

I authorize the doctor to release any information, including the diagnosis and the records of any treatment rendered to myself during the period of such care to third party payers and/or health care practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group, the insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I also understand that I will be held responsible for any services not paid within 60 days of treatment. It is my responsibility to follow-up with my insurance carrier regarding claim status. I agree to pay collection costs and reasonable fees incurred while attempting to collect on any future outstanding balances.

I agree if my insurance requires prior authorization, I must obtain a referral from my primary care physician prior to all office visits and/or all procedures done in our facility. Services provided without prior authorization and/or services not covered by my insurance will be my responsibility.

By signing my name below I certify that all the information on these forms is accurate and true to the best of my knowledge.

Patient Signature: _____ Date: _____

SPACE COAST CARDIOLOGY CONSULTANTS, P.A.

This form is optional and at the discretion of the patient.

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

Patient Name: _____ Chart #: _____

I authorize Space Coast Cardiology Consultants to use and disclose specific Health and Medical information to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

This authorization may be revoked or changed at any time, in writing, at the discretion of the patient.