Capital Cardiology
40 Fuld Street
Suite 400
Trenton, NJ 08638
Phone: (609)396-1644 Fax: (609)394-9526

Patient					
Name (Last,First,MI)	Social Security #	Birthdate	Sex	Home Phone #	
Mailing Address	City	State	Zipcode	Marital Status	
Employer	City	State	Zipcode	Work Phone #	

E- MAIL ADRESS:_____

Primary Physician Address: Phone #:	Referring Physician Address: Phone#:

PHARMACY:
Address:
Phone#:

Emergency Contact Information			
Contact Name	Relationship	Primary Phone #	Secondary Phone #

Patient Release:

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to Insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDERS CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

A copy of this release can be used in place of the original.

Signature: _____ Date: _____

Capital Cardiology Associates, P.A.
40 Fuld Street, Suite 400, Trenton, NJ 08638
Phone: 609-396-1644 Fax: 609-394-9526
Prabodh M. Damani, MD, F.A.C.C. Krishan G. Kalra, MD, F.A.C.C., F.A.C.P.
Muhammad U. Mustafa, MD, F.A.C.C.

Date: _____

Patient Name: (Last)_____(First)_____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____Cell: _____Work: _____

Emergency Contact: _____Relationship: _____

Date of Birth: _____ Age:_____

Marital Status: _____ Number of Children: _____

Employer: _____ Job Duties: _____

Medical Insurance: _____

Family Physician: _____Phone: _____

Referred By: _____

Reason for Office Visit/Consult: _____

_____

Do you have any language, cultural, or religious customs that may affect the care we provide to you?

_____Yes _____No If so, please explain: _____

_____

Cardiovascular History (Please check if you have:)

- ☐ Chest pain, tightness, heaviness
- ☐ Shortness of breath with activity?
- ☐ Do you wake up at night short of breath?
- ☐ Do your legs and ankles swell?
- ☐ Varicose veins (swollen veins on legs)
- ☐ Does your heart skip beats or pounds too fast? (Palpitations)
- ☐ Fainting
- ☐ Dizziness and/or lightheadedness
- ☐ Pain in legs or buttocks when walking?
- ☐ Blood clots in legs or lungs?
- ☐ Rheumatic fever
- ☐ Heart murmur

- ☐ History of heart attack
  Date: _____

- ☐ Heart Catheterization or coronary angiogram
  Date:
  Where:
- ☐ Coronary Balloon Angioplasty or Stent
  Date: _____
  Where: _____

- ☐ Heart Bypass Surgery (CABG)
  Date: _____
  Where: _____
- ☐ Heart Valve Surgery
  Date: _____
  Where: _____
  Which Valve(s): _____
- ☐ Electrophysiological Study (EPS)
- ☐ Pacemaker/Defibrillator
  Implant Date: _____

Coronary Artery Disease Risk Factors (Please check if you have:)

- ☐ Do you smoke or chew tobacco or have you in the past?
  Packs per day: _____
  Years smoked: _____
  Years quit: _____
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Are you diabetic? (blood sugar)

- ☐ Close family members who have or had heart disease, diabetes mellitus, and hypertension. If yes, who and when: _____
  _____
  _____
  _____
  _____

Review of Systems (Please Circle One)

A. GENERAL

- ☐ a. Do you tire easily?
  When did you first notice? _____
- ☐ b. Have you had a recent fever, chills or sweats?
- ☐ c. Skin rashes?
- ☐ d. Have you had a recent weight loss/gain?
  Amount: _____

B. EYES

Have you ever had:

- ☐ a. Blurry vision
- ☐ b. Glaucoma
- ☐ c. Partial or total loss of vision/lenses
- ☐ d. Cataracts

C. THROAT AND MOUTH (CIRCLE WHICH)

- ☐ Do you have any problems with nose, teeth, sinus mouth, throat, ears or hearing?
  Describe: _____
  _____

D. LUNGS

Have you had:

- ☐ a. Asthma or wheezing?
- ☐ b. Emphysema or bronchitis?
- ☐ c. Chronic cough?
- ☐ d. Bloody sputum?

E. GASTROINTESTINAL

Do you have any of the following?

- ☐ a. Heartburn
- ☐ b. Sour regurgitation/acid reflux
- ☐ c. Difficulty swallowing
- ☐ d. Hiatal hernia
- ☐ e. Stomach ulcer
- ☐ f. Rectal bleeding/black or bloody stools
- ☐ g. Gallbladder problems
- ☐ h. Recent change in bowel habits
- ☐ i. Liver disease/Hepatitis

F. GENITO-URINARY TRACT

Do you have any of the following?

- ☐ a. Blood in the urine
- ☐ b. Problems with urination
- ☐ c. Urinary Infections
- ☐ d. Kidney/Bladder Stones
- ☐ e. Kidney Failure/Dialysis
- ☐ f. Do you have nighttime urination?
  How often? _____
- ☐ g. Impotence
- ☐ h. Menopause

G. MUSCULOSKELETAL

Have you had the following?

- ☐ a. Arthritis
- ☐ b. Gout
- ☐ c. Muscle or joint pains

H. ENDOCRINE

- ☐ Have you had thyroid problems?
- ☐ Diabetes?

I. HEMATOLOGY/LYMPHATIC

Have you had any of the following?

- ☐ a. Anemia
- ☐ b. Bruise/bleed easily
- ☐ c. Cancer
  Where: _____
  When: _____

J. NEUROLOGIC

Have you had the following?

- ☐ a. Chronic headaches?
- ☐ b. Dizziness/lightheadedness
- ☐ c. Fainting
- ☐ d. Stroke
- ☐ e. Seizure disorder
- ☐ f. Numbness/tingling

K. PSYCHIATRIC

- ☐ 1. Do you have a history of mental illness?
- ☐ 2. Do you have feelings of depression?
- ☐ 3. Do you have an anxiety problem?

L. HABITS/SOCIAL HISTORY

- ☐ 1. Do you follow a special diet?
- ☐ 2. Do you use caffeine?
  Amount/day? _____
- ☐ 3. Do you use alcohol?
  Amount/day? _____
- ☐ 4. Do you have a history of drug use/abuse?

Medical History (Current/Past)		*Medications (Include Dosage)*

Hospitalizations/Operations		*Allergies(If none, write "none")*

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Diplomates of the American Board of
Internal Medicine and Cardiovascular Diseases

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Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request may state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to use or the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of Our Privacy Practices:

Print Name	Signature	Date

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out 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 necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide 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. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I give authorization for the following people to get information by telephone or pick up any records that I have requested regarding my medical care:

_____ _____
Name Relationship

_____ _____
Name Relationship

I give authorization to Capital Cardiology Associates to leave clinical and appointment messages on the voice mails of the contact phone numbers provided on my registration form.

I give authorization to Capital Cardiology Associates to contact me via my E-Mail address through Patient Health Information Access at this E-Mail Address only:_____

_____ _____ _____
Patient Name Signature Date

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

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NOTICE TO ALL PATIENTS:

All diagnostic testing or procedures scheduled in the office of Capital Cardiology Associates at the above address are subject to the Capital Cardiology cancelation policy as follows:

(Technicians are scheduled in advance and are paid by our office to be here for your scheduled diagnostic test or procedure.)

Cancelations for scheduled office diagnostic testing or procedures must be made 48 hours prior to office diagnostic testing.

Failure to notify the office in less than 48 hours prior to the scheduled diagnostic procedure or testing will result in a bill sent directly to the patient for $50.00. This is not a covered medical insurance benefit and will be payable to the office directly by the patient.

I_____, have read the office cancelation policy stated above. I understand and agree to pay $50.00 for failure to contact the office 48 hours prior to my diagnostic testing appointment.

Signed: _____

Dated: _____

Witness to signature:

_____