(PLEASE PRINT)

REGISTRATION

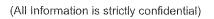
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REGISTRATION Date:				
	PATIENT INF	ORMATIO	N	
Name Last Name	First Name	Middle Initia	Soc. Sec. #	hillian media makin kaliman angan kasasan daga pincinda kala aka aka dan paga dapang apan angapang
Address	rusi name	Middle Initia	Cell Phone	
	State			
	Birthdate			
Whom may we thank for referring you	1?			
	notified? (Other than spouse)			
	PRIMARY IN:	SURANCE		
Person Responsible for Account	Leet Name		Nama	
		1.1121	Ivanic	MIMME IIIMAI
	Birthdate			
	Group #			
CONTROL IT	ADDITIONAL II			
Is patient covered by additional Insura				
Subscriber Name	Relation to Pa	tient	Birthda	te
Address (If different from patient)	professional and professional and the contract of the contract	ang	Phone	Mark harmon property and the seminate of standard and standard habitates of a support company and standard hab
Subscriber Employed by			Business Phone	recording to control of a service of all and a high of a state of the
Insurance Company			Soc. Sec. #	and a supplementary of the sup
Contact #				·····································
Is patient covered by additional Insura	ADDITIONAL IN	VSURANC	E	
Subscriber Name	Relation to Pat	tient	Dishdo	to
			Birthda	
Address (If different from patient)  City				
Subscriber Employed by				
Insurance Company				
Contact #				
			SE	
I, the undersigned certify that I (or my				
			Name of Insurance Compa	* ' '
and assign directly to Dr				
services rendered. I understand that the release all information necessary to se				
release all Information necessary to se	оме те раушенто репешь. таплог	rize trie use t	or this signature on all insurance	submissions.
Phase are all the Phase	Circum and the second	n forest fire better transfer from the services of the service		
Responsible Party	aignature		Relationship	Date

## **HEALTH HISTORY**

(Confidential)

Name	aktivas sammi kaksayina di kata kalifiki yaksi maya injaniyayi asa majayiya ya 19 yaniyayi	Today's Date				
SYMPTOMS Che	eck (🎺) symp	otoms you currently have or hav	e had in the past year.			
GENER	AL	GENITO · URINARY	CARDIOVASCULAR	EYE, EAR, NOSE, THROAT		
☐ Chills		☐ Blood in urine	☐ Chest pain	(Cont.)		
☐ Depression		ロ Frequent urination	☐ High blood pressure	□Nosebleeds		
□ Dizziness		☐ Lack of bladder control	☐ Irregular heart beat	☐ Persistent cough		
☐ Fainting		☐ Painful urination	☐ Low blood pressure	☐Ringing in ears		
□Fever			☐ Poor circulation	☐ Sinus problems		
□Forgetfulness		GASTROINTESTINAL	☐ Rapid heart beat	☐Vision - Flashes		
□Headache		☐ Appetite poor	☐ Swelling of ankles	☐ Vision - Halos		
☐ Loss of sleep		☐ Bloating	*			
•		☐ Bowel changes	☐ Varicose Veins			
☐ Loss of weight		-		014114		
□ Nervousness		☐ Constipation ☐ Diarrhea	EYE, EAR, NOSE, THROAT	SKIN		
□Numbness			☐ Bleeding gums	☐ Bruise easily		
□Sweats		☐ Excessive hunger	☐ Blurred vision	☐ Hives		
		☐ Excessive thirst	☐ Crossed eyes	☐ Itching		
MUSCLE/JOIN	IT/BONE	☐ Gas	☐ Difficulty swallowing	☐ Change in moles		
Pain weakness r	numbness in:	☐ Hemorrhoids	☐ Double vision	□Rash		
□ Arms □	Legs	☐ Indigestion	☐Earache	□Scars		
	Cramping	□ Nausea	☐ Ear discharge	☐ Sore throat won't heal		
	when walking	☐ Rectal bleeding	-	El core unout won theur		
	Neck	☐ Stomach pain	☐ Hay fever			
		☐ Vomiting	☐ Hoarseness			
☐ Hips ☐ Shoulders		☐ Vomiting blood	☐ Loss of hearing			
CONDITIONS C	heck (🎤) sym	nptoms you currently have or ha	ve had in the past year.	and the state of the		
□AIDS		☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problem		
□Alcoholism		☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care		
□Anemia		□ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever		
□Anorexia		□Emphysema	☐ Liver Disease	☐ Scarlet Fever		
□Appendicitis		☐ Epilepsy	☐ Measles	☐ Stroke		
☐ Arthritis		☐Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt		
☐Asthma		☐ Goiter	☐ Miscarriage	☐ Thyroid Problems		
☐Bleeding Disord	iers	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis		
☐Breast Lump		☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis		
☐Bronchitis		☐ Heart Disease	I Mumps	☐ Typhoid Fever		
□Bulimia □Cancer		☐ Hepatitis ☐ Hernia	☐ Pacemaker ☐ Pneumonia	☐ Ulcers		
☐Cataracts		П Herpes	☐ Polio	☐ Vaginal Infections ☐ Vaginal Diseases		
			TARRESTANCE AND ENGINEERING	uaginar Diseases		
ALLERGIES To m	nedications or	SUDSTANCES				
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### FAMILY HISTORY Fill in health information about your family.

Relation	Age		Age at	Cause of Death	Check (✓) if, your blood relatives had any of the following:		
		Health	Death		Disease Relationship to you		
Father					Arthritis, Gout		
Mother	AND THE RESIDENCE OF THE PARTY			ettille ettille saata etti. Kirik saiti etti uuta ota tiit kaita ettiin etti kaita ja ja ja ja kuusissa saata s	Asthma, Hay Fever		
Brothers				redit abstitieren in den zonen detta den anzen en austernistannen obtion sier och zone zen erent bill zusta Ho	Cancer		
				antini ettämisi suuta 2000-tuova kasisistäänä jääkkää yytäyä vanyön yyvetää, konjos olei läytyö että akki yöön	Chemical Dependency		
				1981-960 to be the sector of tracks of the sector control and a subsequence of the sector of the sec	Diabetes		
				Billiothe Amellion (Billion ) and site (ultimately infriend undergring mystypy dominate many groups glight Liquid and provide discharge groups ground and a site of the contract of the contra	Heart Diseas, Strokes		
Sisters				to the control of the	High Blood Pressure		
				https://destruction.edu.org/shis/2000-charactes anno present an education-characteristics/char	Kidney Disease		
				are named and the second s	Tuberculosis		
				mmonenturas arranta assemblyanamentu untu amplikantak indige yaking kaping kapi	Other		

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HOSP Year	ITALIZATIONS Hospital	Reason for H	lospitalization and Ou	utcome		
***************************************						
If yes pl	ou ever had a blood transfusion ease give approximate dates	n? □Yes	□No			
en contrator de la contrator d	RIOUS ILLNESS/INJURIES	DATE	OUTCOME	s	ALTH HABI substances you	TS Check (🗸) which ou use and describe
	medical and the western should be reflected and the state of the state	processing the processing and the processing of the processing the processing of the	PS Medical Artificial State (Ministrated Principle) (Antiferent PS) days broaded at Manufactura paparate abbrevia (ministrated principle)	Allian Andrews (Control of Section (Control of Control	Caffeine	oraniesmit et la prisson giptor des (escolor escolor es ressourcir from siste beneva resistancimos inscrios co
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centry t taff respo	hat the above information is con pnoible for any errors or omissions	rect to the bes that I may have	t of my knowledge. I made in the completion	will not hold on of this form	my doctor c	or any member of his/her

Signature	Date
2000	Date

#### Medications

<u>Drug Name</u> Ex: Metoprolol	<u>Dose</u> 50 mg	<u>Take</u> 1 tablet	Frequency twice a day	How long have you taken this med? Weeks/Months/Years
			vittevativet saturativat erativativat elektronia kan anna elektronia elektronia elektronia elektronia elektronia	
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#### TEXARKANA CARDIOLOGY ASSOCIATES

#### ASSIGNMENT AND RELEASE

Responsible Party Signature	Relationship	Date
Patient Signature	Date of Birth	Date
mare had the opportunity to	receive the riotice of our F	Tivacy Fractices.
have had the opportunity to		
By signing below I am "only"		-
receive a copy of Texarkana	**	* *
I hereby acknowledge that I		
ΔCKNOWI EDGI		IVACY DRACTICES
No I am not Inte	rested in the Patient Web	Portal as this time.
e-mail address		
The Committee of the Co	ted In the Patient Web Po	rtal.
this time.		
address below. If you are no	t interested please check	No I am not interested at
If you would like to use the f	Patient Web Portal please	provide your e-mail
	PATIENT WEB PORTAL	
	* '	
l also release all Rx History	from my participating pha	macy.
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	RX HISTORY RELEASE	
signature on all Insurance s	ubmissions.	
necessary to secure the pay		ze the use of this
paid by Insurance. I hereby		
services rendered that I am	·	
Cardiology Associates all in	surance benefits, if any, of	herwise payable to me for
With	and assign dire	ctly to Texarkana
		it) have Insurance coverage

# **Authorization Form For Release of Protected Health Information**

By signing this form, I authorize you to use and disclose the protected health information (my medical records) described below: Patient Name: The health information you may release is as follows: (please check one) ☐ Entire Medical Record Other (specific) Release my protected health information to the following person(s)/entity: Name/Names: The reasons or purposes for this release of information are as follows: (please check one) ☐Further Medical Care Other (specify) This authorization shall be in force and effective until the following event and/or date: I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice: VICKI FAHR - PRIVACY OFFICER 2604 ST MICHAEL DR. STE 345 • TEXARKANA, TX 75503 903-838-5500 • FAX 903-838-7402 I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whethe I I provide authorization for the requested use or disclosure.

Name of Patient or Personal Representative

Description of personal Representative's Authority

(please print)

Signature of Patient or Personal Representative

Date