(PLEASE PRINT)

REGISTRATION

TEXARKANA CARDIOLOGY ASSOCIATES

Date: _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Middle Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Home Phone _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? (Other than spouse) _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contact # _____ Group # _____ Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contact # _____ Group # _____ Subscriber # _____

ADDITIONAL INSURANCE

Is patient covered by additional Insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contact # _____ Group # _____ Subscriber # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

HEALTH HISTORY

(Confidential)

Name_____ Today's Date _____

Age_____ Birthdate_____ Primary Care Physician_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain weakness numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Cramping when walking
- ☐ Neck
- ☐ Shoulders

GENITO• URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose Veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing

EYE, EAR, NOSE, THROAT (Cont.)

- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore throat won't heal

CONDITIONS Check (✓) symptoms you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Vaginal Diseases

ALLERGIES To medications or substances

(All Information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Diseas, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes please give approximate dates _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME	HEALTH HABITS Check (✓) which substances you use and describe how much you use.		
				Caffeine	
				Tobacco	
				Drugs	
				Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responoible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

NAME: DOB:

Medications

Drug Name Ex: Metoprolol	Dose 50 mg	Take 1 tablet	Frequency twice a day	How long have you taken this med? Weeks/Months/Years

TEXARKANA CARDIOLOGY ASSOCIATES

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have Insurance coverage with _____ and assign directly to Texarkana Cardiology Associates all insurance benefits, if any, otherwise payable to me for services rendered that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance submissions.

RX HISTORY RELEASE

I also release all Rx History from my participating pharmacy.

PATIENT WEB PORTAL

If you would like to use the Patient Web Portal please provide your e-mail address below. If you are not interested please check No I am not interested at this time.

_____ Yes I am Interested In the Patient Web Portal.

e-mail address _____

_____ No I am not Interested in the Patient Web Portal as this time.

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or been given the opportunity to receive a copy of Texarkana Cardiology Associates Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____

Patient Signature Date of Birth Date

_____

Responsible Party Signature Relationship Date

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: _____
(please print)

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 l I provide authorization for the requested use or disclosure.

_____ _____
Signature of Patient or Personal Representative
Name of Patient or Personal Representative
(please print)

_____ _____
Date
Description of personal Representative's Authority