The Arrhythmia Center of South Florida

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NEW PATIENT REGISTRATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Today's Date:		
Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Address:		City, State, ZIP:
Home Phone:	**Cell Phone:**	
Work Phone:	**Other Phone:**	
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Other		
Occupation: ☐ Employed ☐ Retired ☐ Unemployed ☐ Student		
Referring Doctor:	**SSN:**	
****E-mail:**		
Primary Care Physician:		
Cardiologist:		

*By providing your cellphone number, you agree that The Arrhythmia Center of South Florida may deliver to you, at the wireless number provided, text message using an automated system. You may unsubscribe from this service at any time by replying "STOP" to the most recent message received, or by contacting our office. Message and Data rates may apply.

INSURANCE

Primary Insurance:	
ID:	Phone number:
Secondary Insurance:	
ID	Phone number:

PATIENT ONLINE PORTAL ACCESS

**The online portal is a great tool to keep track of your health records. By providing your e-mail address, you are consenting to receive access to the online portal as well as to receive reminders from our practice.

_____ _____

Patient Signature Date

A. Notice of Privacy Practices Patient Acknowledgement Form

Our Notice of Privacy Practices is posted on our website (www.ekgdoctor.com) You may also request a copy from our office staff.

B. AUTHORIZATION FORMEDICAL RECORD RELEASE (BILLING AND CLAIMS PURPOSES)

I hereby authorize The Arrhythmia Center of South Florida and his medical staff to release my medical records to my health insurance company upon request by the insurance company. This includes progress notes, procedural information, hospital notes, medication list, or any additional information in regards to my medical health. I understand that this authorization, except for any action already take, may be voided by me at any time.

C. PATIENT FINANCIAL RESPONSIBILITY

I authorize The Arrhythmia Center of South Florida to submit claims to Medicare and/or other third party payers (Insurance Companies) in exchange for medical related services provided.

I further understand that I am ultimately financially responsible for any charges allowed by Medicare or the third-party payers, not paid my Medicare or third party payers, such as annual deductibles and/or coinsurance (co-pays)

I understand there may be times when a service is not approved or covered by one of the above entities. By my signature below, I choose to obtain these medically related services from The Arrhythmia Center of South Florida with the knowledge that I will be financially responsible for the charges of those services.

If I do not or cannot understand this agreement of financial responsibility, then my authorized representative or medical proxy or power of attorney agrees and understands this financial responsibility, and will sign on my behalf.

By signing below, I have read and understood items A. Notice of Privacy Practices Patient Acknowledgement Form, B. AUTHORIZATION FOR MEDICAL RECORD RELEASE (BILLING AND CLAIMS PURPOSES and C. Patient Financial Responsibility.
By signing here I am also giving permission to The Arrhythmia Center of South Florida to render medical services. I hereby consent and authorize an employee or agent of The Arrhythmia Center of South Florida to take photographs. All photographs will be used for medical chart purposes.

Patient Name (print)

Authorized Representative (if applicable)

Patient Signature

Date

Patient's name: _____

EMERGENCY CONTACT/ CONSENT FOR RELEASE OF INFORMATION

I authorize The Arrhythmia Center of South Florida and staff to release information or records about me to the following individuals. I understand I can cancel the authorization at any time in writing.
In case of emergency please contact:

Name:	Relationship:
Phone Number:	Other Phone Number:
Consent for release on information? ☐	
Name:	Relationship:
Phone Number:	Other Phone number:
Consent for release of information? ☐	

Medication List

Name	Dosage	How many times a day

Are you taking any of these medications?

Anticoagulation	Dose
□ **Coumadin**	
□ **Xarelto**	
□ **Eliquis**	
□ **Pradaxa**	
□ **Savaysa**	

Antiplatelets	Dose
□ **Aspirin**	
□ **Plavix**	
□ **Brilinta**	
Antiarrhythmic	
□ **Amiodarone**	

Pharmacy Name:	Phone Number:
Cross Street:	

Name:_____

Family History

	Living/Deceased	Cardiac Related Problems
Mother	**L / D**	
Father	**L / D**	
Sister	**L / D**	
Brother	**L / D**	
Son/ Daughter	**L / D**	

Cardiac History

Pacemaker?		
Defibrillator?		
Valve Replacement?	**Please circle →**	**Mitral / Aortic/ Tricuspid / Pulmonary If so, Mechanical / Biological**

Surgical History

When?	Where?	Type of surgery

Social History

Alcohol Use	**Tobacco Use**
□Social	□Yes. If so, how many?
□Occasional	□No
□Daily	□Quit Date: _____
How many drinks per day _____	

Name:_____

Medical History

- ☐ Atrial Fibrillation
- ☐ Atrial Flutter
- ☐ SVT
- ☐ PVCs
- ☐ Heart Block
- ☐ Tachycardia
- ☐ Bradycardia
- ☐ Cardiac Arrest
- ☐ Anxiety/ Depression
- ☐ Blood Clots
- ☐ Cancer of_____
- ☐ Congestive Heart Failure
- ☐ Hepatitis
- ☐ HIV/AIDS +/-
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ TIA/ Stroke
- ☐ Chest Pain/ Angina
- ☐ Convulsion/ Epilepsy
- ☐ Diabetes Type_____
- ☐ Emphysema/ Asthma
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Dizziness/ Light Headed
- ☐ Syncope/ Fainting
- ☐ COPD/ Chronic Obstructive Pulmonary Disease
- ☐ Cardiomyopathy
- ☐ Sick Sinus Syndrome/Tachy Brady