THE CARDIOVASCULAR CENTER OF FLORIDA

NEW PATIENT PAPERWORK

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Today's Date: _____

Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Social Security #: _____

Language: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D

Phone: _____ ☐ Cell ☐ Home ☐ Work

E-Mail: _____

Address, City, State, ZIP: _____

Primary MD: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Pharmacy Address: _____

Emergency Contact: _____ Phone: _____

Ethnicity:

☐	Hispanic or Latino	(A person of Cuban, Mexican, Puerto Rican, South or Central American, other Spanish culture or origin, regardless of race)
☐	Not Hispanic or Latino	(A person not meeting the above description for Hispanic or Latino)

☐ REFUSED TO ANSWER

Race:

☐	American Indian or Alaska Native	A person having origins in any of the original peoples of North, Central or South America, and who maintains tribal affiliations or community attachment
☐	Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam"
☐	Black or African American	A person having origins in any of the black racial groups of Africa
☐	Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Island
☐	White	A person having origins in any of the original peoples of Europe, the East, or North Africa

☐ REFUSED TO ANSWER

NEW PATIENT PAPERWORK
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Patient: _____ **Date of Birth:** _____

EMPLOYMENT INFORMATION

Employer: _____ Phone: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's SSN: _____ Gender:

Phone: _____ ☐ Cell ☐ Home ☐ Work

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Secondary Insurance: _____ ID #: _____

Insured's Name: _____ Insured's Date of Birth: _____

MEDICATIONS

Current Medications (list vitamins, supplements, and over-the-counter meds): _____

_____

_____

_____

Allergies: _____

_____

_____

_____

Reason for Visit: _____

_____

_____

_____

_____

NEW PATIENT PAPERWORK
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Name: _____ **Date of Birth:** _____

Referring M.D.: _____ **Primary M.D.:** _____

Have you had any of the following within the past six months:

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Hard to breathe when you lay down flat
- ☐ Swelling of the legs, feet or hands
- ☐ Fainting spells
- ☐ Light headedness/dizziness
- ☐ Tiredness
- ☐ Palpitations
- ☐ Any circulatory problems
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Headaches
- ☐ Visual problems
- ☐ Fever
- ☐ Coughing
- ☐ Urinary problems

Have you had any of the following tests/procedures done:

- ☐ Angioplasty
- ☐ Bypass surgery
- ☐ Heart catheterization
- ☐ Echocardiogram
- ☐ Holter/Event monitor
- ☐ Stress test (exercise, nuclear, PET)

Do you have any of the following:

- ☐ Alcohol usage
- ☐ Angina
- ☐ Asthma/COPD
- ☐ Blood clots
- ☐ Carotid artery disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ Family history of heart disease
- ☐ Gangrene
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart problems as a child
- ☐ Heart valve disorders
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Infection of the heart
- ☐ Internal bleeding
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Nicotine usage
- ☐ Peptic ulcer
- ☐ Reflux
- ☐ Seizures
- ☐ Skin problems
- ☐ Sleep apnea
- ☐ Thyroid problems

Does any member of your immediate family have:

- ☐ Alcohol usage
- ☐ Angina
- ☐ Asthma/COPD
- ☐ Blood clots
- ☐ Carotid artery disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ Family history of heart disease
- ☐ Gangrene
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart problems as a child
- ☐ Heart valve disorders
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Infection of the heart
- ☐ Internal bleeding
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Nicotine usage
- ☐ Peptic ulcer
- ☐ Reflux
- ☐ Seizures
- ☐ Skin problems
- ☐ Sleep apnea
- ☐ Thyroid problems

NEW PATIENT PAPERWORK
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Patient: _____ Date of Birth: _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES AND AMOUNTS NOT PAID BY MY INSURANCE CARRIER

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

SIGNED: _____

Date:_____

I authorize payment of medical benefits to Dr. Mark Steiner, or The Cardiovascular Center of Florida for services rendered to me.

SIGNED: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of The Cardiovascular Center of Florida "Notice of Privacy Practices."

and

I authorize information to be disclosed with/released to another individual: ☐ YES ☐ NO

Individual's Name: _____ Relationship: _____

Individual's Name: _____ Relationship: _____

I consent to information being left on my voicemail/answering machine: ☐ YES ☐ NO

_____	_____	_____
Name (Please Print)	Signature	Date

FOR CARDIOVASCULAR INSTITUTE OF CENTRAL FLORIDA

Date acknowledgement was received: _____

OR

Reason acknowledgement was not obtained: _____

_____

_____	_____	_____
Employee Name (Please Print)	Signature	Date

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Orlando, FL 32819
407-738-4200 phone
407-705-2540 fax