Cardiovascular Associates
CVA OF CENTRAL FLORIDA

New Patient Registration

(Please complete, print, sign, and bring at you visit)

Individual Information

Name:		DOB: (mm/dd/yyyy) Sex: ☐M ☐F	
Social Security Number:		Marital Status: ☐Single ☐Married ☐Other	
Mailing Address of Patient: Street		City	
State	Zip Code	Home Phone:	Cell Phone:
Race: ☐Caucasian ☐African American ☐Hispanic ☐Asian ☐Other ☐Refuse to Report			
Preferred Language: ☐ English ☐ Spanish ☐ Other			
Email:		Would you like to receive our email newsletter? Yes No	

Referral and Contact/s Information

Primary Care Physician:	Referring Physician:	
Previous Cardiologist:	Address:	Phone:
Pharmacy:	Address:	Phone:
Next of Kin and/or Health Care Proxy:	Relationship:	Phone:
Do you have an Advance Directive? ☐ No Advance Directive ☐Health Care Proxy ☐Power of Attorney ☐Living Will		
How did you find out about us? ☐Friend ☐ Relative ☐Doctor ☐ Internet ☐ Advertisement ☐Insurance Book ☐ Hospital Visit ☐ Other		
May we leave general messages on your home/cell phone about appointments/test results? ☐Yes ☐No		
Would you permit us to get your medication list from your Pharmacy if you cannot remember? ☐Yes ☐No Do you have any specific restrictions about handling your Protected Health Information? ☐ No ☐Yes		

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Primary Insurance Information

Primary Insurance Company:		Employer:
Policy Number:		Group Number:
Policy Holder: ☐ Self (if self go to next page) ☐ Other (fill next rows):		
Policyholder Name:	Relation to Patient:	Birth Date(mm/dd/yyyy):
Social Security Number:	Address (if different from patient):	
Phone:	Employer:	

Secondary Insurance Information

Secondary Insurance Company:		Employer:
Policy Number:		Group Number:
Policy Holder: ☐ Self (if self go to next page) ☐ Other (fill next rows):		
Policyholder Name:	Relation to Patient:	Birth Date(mm/dd/yyyy):
Social Security Number:	Address (if different from patient):	
Phone:	Employer:	

Renewal of Patient Registration

☐ By checking this box, I attest that there is no material change in my individual patient information, referral/contact information and insurance information from my prior registration. (Initials)

Insurance Benefits: Financial Arrangement

I assign, transfer and send over to Cardiovascular Associates, CVA of Central Florida all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. I understand that I am financially responsible for any charges not covered by my insurance company such as co-payments, co-insurances, deductibles, or returned check processing fees. I also understand that if Physician(s) of Cardiovascular Associates, CVA of Central Florida does not have a contract with my insurance, Cardiovascular Associates, CVA of Central Florida will submit charges to my insurer or an unassigned basis for services rendered to me. In such event, I understand that my insurer may send the payment directly to me for these services. If I receive such payments and/or correspondences from my insurer for services rendered by Physician(s) of Cardiovascular Associates , CVA of Central Florida, I agree to submit these to Cardiovascular Associates, CVA of Central Florida. In the event of any default, I understand that I could be referred to collection agency, and subject to pay interest, collection cost, and/or reasonable attorney fees. This authorization shall remain valid until written notice is given by the authorized person to terminate said agreement. By signing, you agree that you understand and accept the terms on this form.

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Attention

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and incapable of signing, a** legally authorized substitute may sign and date the form. Please indicate you legal authority and include documentation of your relationship.

  Legal Guardian: **Health Care Agent:**
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form unless exception exists under federal law. Please indicate your relationship:

  Legal Guardian: **Health Care Agent:**

Signature (Required)	**Date Signed** (Required) (mm/dd/yyyy)
Print Name of Person Signing (In not Patient)	

Patient Medical History

(Historial Medico Del Paciente)

Age: _____ *Edad* Date Of Birth: _____ Fecha de Nacimiento Birth Place: _____ Lugar De Nacimiento

Name: Nombre Mr./Sr. Mrs./Sra. Miss./Srta _____ Last/Apellido Middle/Segundo Nombre First/Primer Nombre

Date: _____ Fecha

Why Were You Referred Here:
Cual Es El Motivo De Su Vista?

1.
2.
3.
4.

Allergies/Alergias:

1.
2.

Current Medications?
Medicamentos Que Toma
Dosage/Instruction? Dosis/Instrucciones?

1.
2.
3.
4.
5.
6.
7.

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Recent, Chronic, Or Recurrent Symptoms (circle all that apply)
Sintomas Recientes, Cronicos, O Recurrentes (encierre en un circulo todos los que correspondan)

Chest discomfort (molestias en el pecho)
Fainting or near fainting (Desmayos o Casi Desmayos)
Major weight gain or loss (Aumento o Perdida De Peso)
Abdominal pain (Dolar abdominal)
Dizziness (Mareo)
Short of breath (Falta de aliento)
Fatigue (Fatiga)
Fever (Fiebre)
Anxiety (Ansiedad)
Depression (Depresion)
Palpitation (Palpitacion)
Swelling (Hinchazon)
Cough (Tos)
Significant Bleeding (Sangrado significativo) Where? (De Donde?)

Past Or Current Medical Problems (circle all that apply)
Problemas Medicos Pasados O Actuales (encierre en un circulo todos los que correspondan)

Cardiovascular Disease:
Coronary Artery Disease (Arteriopatía Coronaria)
Atrial Fibrillation (Fibrilación Auricular)
Aortic Aneurysm (Aneurisma Aortico)
Myocardial Infarction/ Heart Attack (Infarto De Miocardio/Ataque Cardíaco)
Hypertension (Hipertensión)
High Cholesterol (Colesterol Alto)
Other Cardiac Arrythmias (Otras Arritmias Cardíacas)
Congestive Heart Failure (Insuficiencia Cardíaca Congestiva)

Respiratory Disease:
COPD
Emphysema (Enfisema)
Asthma (Asma)
Obstructive Sleep Apnea (Apnea Obstructiva Del Sueño)
Pulmonary Embolism (Embolia Pulmonar)

Gastroenterology:
Cirrhosis (Cirrosis)
Colitis
GI Bleeding (Sangrado Gastrointestinal)
GERD (Enfermedad Por Relujo Gastrointestinal)

Cardiovascular Disease Of Pregnancy:
Pre-eclampsia/Eclampisa
Gestational Diabetes (Diabetes Gestacional)
Gestational Hypertension (Hipertensión Gestacional)
Peripartum Cardiomyopathy (Miocardiopatía Periparto)
Other (Otro)

Nervous System:
CVA/Stroke ACV/Accidente Cerebrovascular)
Parkinson's (Enfermedad De Parkinson)
Dementia/Alzheimer's (Demencia/ Enfermadad De Alzheimer)
Seizures (Convulsiones)

Endocrine:
Diabetes
Thyroid Disease (Enfermedad De Tiroides)

Infectious Disease:
HIV/AIDS
Shingles
Pneumonia
Tuberculosis

Rheumatology:
Arthritis (Artritis)
Lupus
Rheumatoid Arthritis (Artritis Reumatoide)

Others:
Liver Cirrhosis (Cirrosis Hepática)
Chronic Kidney Disease/Failure (Enfermedad/Insuficiencia Renal Crónica)
Deep Vein Thrombosis (Trombosis Venosa Profunda)
Peripheral Arterial Disease (Enfermedad Arterial Periférica)
Carotid Artery Disease (Enfermedad De La Arteria Carótida)

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Previous Surgery:

Surgery: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Social History:

Are you a smoker? ☐ YES ☐ NO
If yes, how many daily?
☐ Former Smoker
When did you quit?

Do you drink alcohol? ☐ YES ☐ NO
If yes, how much?

Do you use illicit drugs? ☐ YES ☐ NO
If yes, what drug and how often?

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Cardiovascualr Associates, Inc.
Johnson Massey, MD, FACC
Patrick Mathias, MD, FACC, FCCP, FACAI, FACP
Robert Barrett , MD, FACC
Thomas Kim, MD
Mukesk Kumar, MD, FACC, FSCA
Naushad Shaik, MD, FACC, FHRS, CCDSI
Jooby John, MD, FACC, FSCAI
James Warren, MD, FACC
George Gobrial, MD
Salah Din, MD, FACC
Jonathan Massey, MD

Bethanne Smith, APRN
Brent Boro, APRN
Ashley Cavallaro, APRN
Allison Germaine, APRN
Dawna Hazelwood, APRN
Petula Indar, APRN
Assel Kaliyeva, APRN

Authorization To Obtain/Release Medical Records

Cost for records ($1 per page for 1st 25 pages, after that each page is $0.25)

Patient's Name/Previous Name _____ Date of Birth/Social Security Number _____

Street Address _____ City, State, and Zip Code _____

Authorizes:	To Obtain/Release protected health information from:
Cardiovascular Associates , Inc 601 Oak Commons Blvd, Kissimmee, Fl 34741 Phone: (407)-846-0626 Fax: (407)-846-2371	

Information to be obtained: I hereby authorize you to obtain/release my medical records for any treatment and laboratory/diagnostic tests preformed such as:

H&P/Consult/Discharge	Echo/Doppler	Lab/EkG	Stress/Cath/Bypass	XRay/MRI
Records from other facilities and providers	All			

Except For:

Sexually Transmitted Disease	HIV	Drug Abuse Treatment	Alcohol Abuse Treatment
Mental Health Treatment	For the following dates:		

Purpose For Need Of Disclosure:

Further Medical Care	Insurance Eligibility
Other (Please Specify):	

Your rights with respect to this authorization: I understand that I must be provided with a signed copy of tis authorization. I understand written notification is necessary to cancel this authorization and I have the right to revoke this authorization by requesting to revoke and completing this revocation section of the form below if Cardiovascular Associates, Inc has not acted in reliance in this authorization. I f I decide not to sign this form, Cardiovascular Associates, Inc will not refuse to continue treatment. By singing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the Person/Doctor/Agency named above. I understand that if the person and /or the organization listed above are not mandated by the federal privacy standards, the information disclosed as a result or this authorization may be redisclosed without my authorization. I understand that I may be charged a fee for copying these medical records.

Signature of Patient: _____ **Date:** _____
Signature of Patient's Legal Representative: _____
Relationship to Patient: _____
Expiration Date: This authorization is good until the following date _____ or one year from date of signature.

Revocation

(To be completed by the patient if the patient subsequently wishes to revoke authorization.)
I hereby revoke this authorization. **Signature:** _____ **Date:** _____