Advanced Cardiology of South Jersey®

PATIENT REGISTRATION FORM **Today's Date:**_____

Please complete this form in order to ensure proper billing of your services. Please Print.

PATIENT INFORMATION

Patient Last Name:_____ Social Security Number:_____

First Name:_____ MI:_____ Date of Birth:_____

Other Name:_____ Race: (please choose one of the following):

Martial Status: ☐ Single ☐ Married ☐ Widowed ☐ American Indian or Alaska Native ☐ White ☐ Asian
☐ Separated ☐ Divorced ☐ Other ☐ Native Hawaiian/ Pacific Islander
☐ Black or African American ☐ Patient Declined

Addr1:_____ Ethnicity:☐ Hispanic/Latino ☐ Not Hispanic/Latino

Addr2:_____ ☐ Patient Declined

City:_____ State:_____ Zip_____ Home Phone: (_____)_____

Preferred Method of Contact: ☐ Alt Phone Number ☐ Email Alt Phone: (_____)_____

☐ Letter ☐ Phone Call (Cell) ☐ Phone Call (Home) Home Email:_____

Driver's License #_____ State_____ Cell Phone: (_____)_____

Emp. Status: ☐ Employed Full Time ☐ Employed Part Time Employer:_____

☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student Address:_____

☐ Active Military ☐ Self Employed ☐ Other_____ City:_____ State:_____ Zip:_____

Language: ☐ English ☐ Spanish ☐ Other_____ Work Phone: (_____)_____

INSURANCE INFORMATION

PRIMARY CARRIER:_____ Telephone:_____

Address:_____ ID/Cert #:_____

Group/Plan #:_____ Effective Date:_____ Subscriber's Name:_____

Subscriber's DOB:_____ SSN:_____ Relationship to Patient:_____

Sex: ☐ Male ☐ Female Subscriber's Employer:_____

SECONDARY CARRIER:_____ Telephone:_____

Address:_____ ID/Cert #:_____

Group/Plan #:_____ Effective Date:_____ Subscriber's Name:_____

Subscriber's DOB:_____ SSN:_____ Relationship to Patient:_____

Sex: ☐ Male ☐ Female Subscriber's Employer:_____

PHYSICIAN CARE INFORMATION

PRIMARY CARE PHYSICIAN NAME: _____

COMPANY NAME: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (_____) _____

REFERING PHYSICIAN NAME (if different): _____

COMPANY NAME: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (_____) _____

GUARANTOR INFORMATION

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)

Guarantor _____ Patient's Relationship to Guarantor : _____

Addr1: _____ Social Security Number: _____

Addr2: _____ Date of Birth: _____ Sex: □ Male □ Female

City: _____ State: _____ Zip _____

Home Phone:(_____) _____ Cell Phone:(_____) _____

Employer: _____

Address: _____ City: _____ State: _____ Zip _____

Work Phone:(_____) _____ Driver's License # _____ State _____

Guarantor E-mail: _____

How did you hear about our practice?

□ Internet □ Newspaper/Magazine □ Patient □ Phone Book

□ Physician Office/Hospital Emergency □ Relative □ Word of Mouth □ Other _____

Name: _____

Advanced Cardiology of South Jersey®

Account #: _____

Assignment of Benefits/ Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Advanced Cardiology of South Jersey, PC - Payment Policy and Notice of Privacy Practices for more information)

Use of Photograph Identification

The undersigned agrees that any patient photograph identification taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

_____ _____

Patient Name (Please Print) Patient Signature

_____

Guarantor/Parent/Guardian completing this form (Please Print) Date

_____

Guarantor/Parent/Guardian Signature Date

Advanced Cardiology of South Jersey®

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	□Y □N
Has treatment been authorized by the V.A.?	□Y □N
Are you covered under the Black Lung Program?	□Y □N
Do you or your spouse have other insurance?	□Y □N
Are you disabled or have end stage renal disease?	□Y □N
Is illness/injury the result of an auto accident?	□Y □N
Did illness/injury occur at work?	□Y □N
Is there Medigap coverage secondary to Medicare?	□Y □N
Is there insurance coverage primary to Medicare?	□Y □N
Is there employer supplemental coverage secondary to Medicare?	□Y □N

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical Information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Name (Please Print) _____ Patient Signature _____

Guarantor/Parent/Guardian completing this form (Please Print) _____ Date _____

Guarantor/Parent/Guardian Signature _____ Date _____

Advanced Cardiology of South Jersey®

HIPAA ACKNOWLEDGEMENT

Notice of Privacy Practices

Printed Name of Patient: _____

Patient Date of Birth: _____

I acknowledge receipt of Advanced Cardiology of South Jersey, PC Notice of Privacy Practices.

Signature of Patient / Legal Representative: _____

Date: _____

****

Office Use:

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individuals acknowledgement, and the reason why the acknowledgement was not obtained.

Reason: _____

Signature of Advanced Cardiology of South Jersey, PC Employee: _____

Printed Name: _____ Date: _____

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CONSENT, DISCLOSURE AND AUTHORIZATION FORM

Patient Name:_____ Acct #_____

Address:_____ DOB: _____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize Advanced Cardiology of South Jersey, PC, Dr. Vishal Bahal and ancillary medical personnel of Advanced Cardiology of South Jersey, PC, to perform medical examinations and provide routine medical care for all my visits to Advanced Cardiology of South Jersey, PC. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of Advanced Cardiology of South Jersey, PC. Any photographs or other images taken will become part of my medical record. Advanced Cardiology of South Jersey, PC will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Advanced Cardiology of South Jersey, PC will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and understand Advanced Cardiology of South Jersey, PC HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that Advanced Cardiology of South Jersey, PC has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, Advanced Cardiology of South Jersey, PC will post a new notice in the office. I may contact Advanced Cardiology of South Jersey, PC at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. I may also access a copy on its website.

Consent To Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize Advanced Cardiology of South Jersey, PC to use and disclose my health information, which includes all or any part of my medical records, including drug or alcohol treatment information, genetic, genetic counseling and genetic testing information, HIV I AIDS information, and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of Advanced Cardiology of South Jersey, PC. I understand that, for example, my health information may be used or disclosed by Advanced Cardiology of South Jersey, PC to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by Advanced Cardiology of South Jersey, PC; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand Advanced Cardiology of South Jersey, PC may release my protected health information as required by law or court order.

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Patient Name: _____ DOB: _____

Disclosures to Authorized Individuals

I understand that Advanced Cardiology of South Jersey, PC release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name: _____ Relationship: _____

Address _____

Phone: (_____) _____

Health Information: YES NO (circle as applicable) Payment Information: YES NO (circle as applicable)

Name: _____ Relationship: _____

Address _____

Phone: (_____) _____

Health Information: YES NO (circle as applicable) Payment Information: YES NO (circle as applicable)

Name: _____ Relationship: _____

Address _____

Phone: (_____) _____

Health Information: YES NO (circle as applicable) Payment Information: YES NO (circle as applicable)

CONTACT INFORMATION

I wish to be contacted in the following manner (Please check all that apply):

☐ Home Telephone _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Work Telephone _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Cell Telephone _____ ☐ Detailed Message ☐ Call Back Message Only

☐ Mail to Home Address ☐ Mail to Home Address

Mailing Address: _____

I understand that if I have checked the box "detailed message," I agree that Advanced Cardiology of South Jersey, PC may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/financial issues, test results, and any other information regarding care/treatment.

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ADVANCE DIRECTIVE

Patient Name:_____ Date:_____

Instructions: Check yes or no to the first question. If you answer yes, please pick which type and answer remaining questions.

1. Do you have an Advance Directive? (Living Will)

☐ Yes ☐ No

Only answer following questions if your answer is yes for question 1.

2. What is your DNR status?

☐ No Code ☐ Partial Code ☐ Full Code

3. Does the patient wish to be provided nutrition or hydration via feeding tube?

☐ Yes ☐ No

4. Does the patient wish to receive antibiotics?

☐ Yes ☐ No

5. Are you an organ donor?

☐ Yes ☐ No

Name of Power of Attorney: _____

Phone Number for Power of Attorney: _____

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USE OF CONSENT AND AUTHORIZATION

A copy of this consent and authorization may be used in place of the original.

CONSENT AND AUTHORIZATION

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name:_____

Patient Signature:_____ Date:_____

Authorized Individual (Parent/Guardian) Name: _____

Authorized Individual Signature:_____

Basis of Authority (e.g., Parent, Guardian): _____

Advanced Cardiology of South Jersey®

TELEPHONE CONSUMER PROTECTION ACT (TCPA)

You agree, in order for us to service your account or to collect monies you may owe, Advanced Cardiology of South Jersey, PC, and/ or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/ artificial voice messages and / or use of automatic dialing device, as applicable.

I / We have read this disclosure and agree that Advanced Cardiology of South Jersey, PC, its employees and / or agents may contact me/ us as described above.

Responsible Party Signature:_____

Date:_____

ACSJ ELECTRONIC MEDICAL RECORD QUESTIONNAIRE

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

SSN: _____ E-mail Address: _____

Emergency Contact Person(who doesn't live with you): _____

Phone Number of Emergency Contact Person: _____

Doctor's Name	Type of Doctor	Doctor's Address

PAST CARDIAC HISTORY

Have you had any of the following problems:

1. Heart Attack? Yes [ ] No [ ]
2. Valvular heart Disease? Yes [ ] No [ ]
3. Pain or discomfort in chest, arms, throat, jaw or upper back? Yes [ ] No [ ]
4. Congestive Heart Failure? Yes [ ] No [ ]
   a. Shortness of breath with mild exertion? Yes [ ] No [ ]
   b. Awaken at night because of shortness of breath? Yes [ ] No [ ]
   c. Swelling of ankles or feet? Yes [ ] No [ ]
5. High blood pressure (Hypertension)? Yes [ ] No [ ]
6. Rheumatic Fever or Rheumatic Heart Disease? Yes [ ] No [ ]
7. Infection in the heart (SBE or infections endocarditis)? Yes [ ] No [ ]
8. Pericarditis? Yes [ ] No [ ]
9. Stroke or Mini-Stroke? Yes [ ] No [ ]
   Transient Ischemia Attack (TIA)? Yes [ ] No [ ]
10. Palpitations, skips, irregular or abnormal heart rhythms? Yes [ ] No [ ]
11. Blackouts or fainting spells? Yes [ ] No [ ]
12. Frequent dizzy spells or light-headedness? Yes [ ] No [ ]
13. Pains or cramps in legs (especially in calves)? Yes [ ] No [ ]
    [ ] While walking? [ ] In bed at night?
14. History of Phlebitis or blood clots in veins or legs? Yes [ ] No [ ]
15. History of blood clots in lungs (Pulmonary Embolus)? Yes [ ] No [ ]
16. History of a heart murmur? Yes [ ] No [ ]
17. History of abnormal EKG (Electrocardiogram)? Yes [ ] No [ ]
18. History of abnormal chest x-ray? Yes [ ] No [ ]
19. Heart Catheterization, coronary angioplasty, or coronary stenting? Yes [ ] No [ ]
20. Angioplasty or stenting in blood vessels other than your heart (eg. legs)? Yes [ ] No [ ]

ACSJ ELECTRONIC MEDICAL RECORD QUESTIONNAIRE

21. Have you had heart surgery----Bypass or Heart Valve surgery? Yes [ ] No [ ]
22. Surgery on arteries other than in the heart (eg. neck, aorta, legs,etc.)? Yes [ ] No [ ]
23. Do you have a pacemaker? Yes [ ] No [ ]
24. Do you have an automatic implantable defibrillator (AICD)? Yes [ ] No [ ]

RISK FACTOR SUMMARY (Please check all that apply)

_____Diabetes

_____High Blood Pressure (Hypertension)

_____High Cholesterol

_____Overweight by more than 10lbs

_____Family History of Heart Disease

_____Prior Heart Trouble

_____No Exercise

_____Reached Menopause

_____Smoking

PAST MEDICAL HISTORY (Please list other medical problems such as ulcers, thyroid, liver or kidney problems, gastric reflux, rheumatoid arthritis, etc.)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PAST SURGICAL HISTORY What surgery did you have and when did you have it?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication Name	Strength	Frequency	Prescribing Doctor

ACSJ ELECTRONIC MEDICAL RECORD QUESTIONNAIRE

ALLERGIES

Are you Allergic to Iodine, Radiographic Contrast Dye or Seafood? Yes [ ] No [ ]

Are you Allergic to any Medications? If yes, please list below: Yes [ ] No [ ]

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY

Relation	Age	Health Issue	Age at Death	If Deceased Cause
Father				
Mother				
Brothers				
Sisters				

SOCIAL HISTORY AND LIFESTYLE

ALCOHOL HISTORY: Do you currently drink? Yes [ ] No [ ]
How many alcoholic beverages (beer, wine, or liquor) do you drink on an average day? _____

SMOKING HISTORY: Do you currently smoke? Yes [ ] No [ ]
What do you smoke? _____

Number of packs per day?_____ Number of years you have smoked?_____
If you quit smoking, when did you quit?_____

How many cups of caffeinated beverages do you drink on an average day?_____
Do you exercise on a regular basis? Yes [ ] No [ ]

MARITAL STATUS: [ ] Single [ ] Domestic Partnership [ ] Married [ ] Civil Union [ ] Divorced [ ] Widowed
How many children do you have? _____
What is the highest grade of formal education that you finished? _____
Your Occupation? _____

ACSJ ELECTRONIC MEDICAL RECORD QUESTIONNAIRE

REVIEW OF SYSTEMS

Instructions: Check yes or no to all of the following questions. If you answer yes, please explain on the right side of the page.

GENERAL			REASON
Decreased exercise tolerance?	Yes [ ]	No [ ]	
Fatigue	Yes [ ]	No [ ]	
Weight Change? [ ] Gain [ ] Loss	Yes [ ]	No [ ]	
How Much?			
Period of time?			
Change in Appetite?	Yes [ ]	No [ ]	

INTEGUMENTARY (SKIN)			REASON
Changes in moles?	Yes [ ]	No [ ]	
Rash?	Yes [ ]	No [ ]	
Itching?	Yes [ ]	No [ ]	
Changes in hair?	Yes [ ]	No [ ]	
Changes in nails?	Yes [ ]	No [ ]	

EYES			REASON
Do you wear glasses?	Yes [ ]	No [ ]	
Do you have blurred vision?	Yes [ ]	No [ ]	
Do you experience double vision?	Yes [ ]	No [ ]	
Do you have a history of cataracts?	Yes [ ]	No [ ]	
Glaucoma?	Yes [ ]	No [ ]	
Have you experienced visual field loss?	Yes [ ]	No [ ]	

EARS, NOSE AND THROAT			REASON
Do you have a hearing deficit?	Yes [ ]	No [ ]	
Dizziness with changing position?	Yes [ ]	No [ ]	
Chronic sinus problems?	Yes [ ]	No [ ]	
Do you have nose bleeds?	Yes [ ]	No [ ]	
Do you wear dentures?	Yes [ ]	No [ ]	
Hoarseness/ Change in voice?	Yes [ ]	No [ ]	

RESPIRATORY			REASON
Do you have a chronic cough?	Yes [ ]	No [ ]	
Productive?	Yes [ ]	No [ ]	
Have you coughed up blood?	Yes [ ]	No [ ]	
Do you experience shortness of breath?	Yes [ ]	No [ ]	
[ ] At rest? [ ] With activity?			
Do you wheeze?	Yes [ ]	No [ ]	
Do you snore?	Yes [ ]	No [ ]	

ACSJ ELECTRONIC MEDICAL RECORD QUESTIONNAIRE

CARDIOVASCULAR			REASON
Chest pain, pressure or tightness	Yes [ ]	No [ ]	
[ ] At rest? [ ] With activity?			
Heart palpitations (racing)?	Yes [ ]	No [ ]	
Irregular heart beats?	Yes [ ]	No [ ]	
Short of breath lying flat?	Yes [ ]	No [ ]	
How many pillows do you sleep with?			
Waking up panicky short of breath?	Yes [ ]	No [ ]	
Have you passed out?			
Swelling of feet or ankles?	Yes [ ]	No [ ]	
Pain in legs with walking?			
Describe distance before pain develops.			
Varicose veins?	Yes [ ]	No [ ]	
Nonhealing sores on legs or feet?	Yes [ ]	No [ ]	

GASTROINTESTINAL SYSTEM			REASON
Frequent nausea?	Yes [ ]	No [ ]	
Frequent vomiting?	Yes [ ]	No [ ]	
Frequent diarrhea?	Yes [ ]	No [ ]	
Problems with constipation?	Yes [ ]	No [ ]	
Blood in stool?	Yes [ ]	No [ ]	
Gallbladder problems?	Yes [ ]	No [ ]	
Liver problems?	Yes [ ]	No [ ]	

GENITOURINARY			REASON
Do you have pain with urination?	Yes [ ]	No [ ]	
Blood in urine?	Yes [ ]	No [ ]	
Sense of urgency to urinate?	Yes [ ]	No [ ]	
Awaken frequently to urinate?	Yes [ ]	No [ ]	
History of bladder, kidney infection?	Yes [ ]	No [ ]	
History of kidney stones?	Yes [ ]	No [ ]	
Males: Prostate problems?	Yes [ ]	No [ ]	
Females: Post menopausal?			

MUSCULOSKELETAL			REASON
Chronic back pain?	Yes [ ]	No [ ]	
Arthritis?	Yes [ ]	No [ ]	
History of gout?	Yes [ ]	No [ ]	
History of blood clots in legs?	Yes [ ]	No [ ]	
History of vein ligation or stripping?	Yes [ ]	No [ ]	

ENDOCRINE			REASON
High Cholesterol?	Yes [ ]	No [ ]	
Diabetes?	Yes [ ]	No [ ]	
Thyroid Problems?	Yes [ ]	No [ ]	

ACSJ ELECTRONIC MEDICAL RECORD QUESTIONNAIRE

NEUROLOGICAL			REASON
Temporary blurred vision/loss of vision?	Yes [ ]	No [ ]	
Temporary weakness and/or tingling involving an arm or leg?	Yes [ ]	No [ ]	
Severe headaches?	Yes [ ]	No [ ]	
Migraine Headaches?	Yes [ ]	No [ ]	
Convulsions/Seizures?	Yes [ ]	No [ ]	

HEMATOLOGICAL/ IMMUNOLOGIC			REASON
Chronic low blood count/anemia?	Yes [ ]	No [ ]	
Bleeding problems?	Yes [ ]	No [ ]	
Seasonal Allergies?	Yes [ ]	No [ ]	
Latex Allergy?	Yes [ ]	No [ ]	

PSYCHIATRIC			REASON
Do you have a history of depression?	Yes [ ]	No [ ]	
Do you have chronic anxiety?	Yes [ ]	No [ ]	

I have reviewed the above statements and to the best of my ability the information provided is a correct representation of my medical history.

Signed _____ Date _____