Capital Cardiology Associates

CARING FROM THE HEART | A BENCHMARK CARDIOLOGY PRACTICE℠

www.capitalcardiology.com

AFFIX LABEL HERE

PATIENT INFORMATION SHEET

GENERAL INFORMATION

MRN _____ **Preferred Name** _____

(To facilitate insurance payment, please write name exactly as written on your primary insurance card)

Patient Name _____

DOB _____ **Sex** ☐ M ☐ F ☐ Undifferentiated **Birth Gender** _____

Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Multiracial ☐ Other ☐ Pt Declined

Ethnicity ☐ Not Latino or Hispanic ☐ Latino or Hispanic ☐ Pt Declined ☐ Unknown

Preferred Language ☐ English ☐ Spanish ☐ Other: _____ Do you need a translator? ☐ Yes ☐ No

Are you deaf or hearing impaired? ☐ Yes ☐ No ☐ I need a sign language interpreter.

Social Security Number _____ **(Only used for insurance verification/avoid duplication)**

Do you have an Advance Directive, Living Will, DNR, Health Care Proxy and/or Power of Attorney (POA)? ☐ Yes ☐ No

Who referred you to our office? ☐ ER ☐ Hospital ☐ Primary MD ☐ Friend/Relative ☐ Self ☐ Other MD

How did you hear about us? ☐ Hospital ☐ Primary MD ☐ Other MD ☐ Radio, TV, Social Media, Print Media, Internet ☐ Friend/Relative

PATIENT CONTACT INFORMATION

Address 1 _____

City/State/Zip _____

Address 2 _____

City/State/Zip _____

		May Text	Preference
Home Phone	_____	☐	☐
Cell Phone	_____	☐	☐
Work Phone	_____	☐	☐

Email address _____

Do you wish to sign up for the CCA Patient Portal? (email address required) ☐ Yes ☐ No

(**Note:** The portal allows you to send a **non-urgent** message to your provider and for CCA to send a secure message to you. Patients may use the portal to request test results or a document to be placed on the portal for you to access.)

MEDICAL INFORMATION

Primary Care Physician (PCP) _____ Phone _____

Preferred Pharmacies

Local:

Name _____

Address _____

City/State/Zip _____

Phone _____

Mail Order:

Name _____

Address _____

City/State/Zip _____

Phone _____

COMPLETE OTHER SIDE ➔

OTHER PERSONAL CONTACTS

Name_____ Name_____

Relationship _____ Relationship _____

Phone _____ Phone _____

Email _____ Email _____

Comment_____ Comment _____

Please consider this person as (check all that apply)

_____ Emergency Contact _____ Next of Kin

I authorize CCA to discuss my treatment and medical condition with this person in accordance with HIPAA law. _____ YES _____ No

Please consider this person as (check all that apply)

_____Emergency Contact _____Next of Kin

I authorize CCA to discuss my treatment and medical condition with this person in accordance with HIPAA law. _____ YES _____ No

Note: Please notify us if you wish to add or remove contacts, or change status as an emergency contact, next of kin, and/or HIPAA authorized contact.

INSURANCE

Prescription Payment Plan Name *(if not listed above)*

Name_____ **ID#**_____ **Copay**_____

Supply paperwork related to Workman's Compensation or a No Fault Claim. Date of Accident/Injury_____

Insurance Carrier_____ Claim #_____

Adjuster Name _____ Phone #_____

CONSENT

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plans to Capital Cardiology Associates. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize Capital Cardiology Associates to release all necessary information to secure payment.

Initials _____

I understand that I am responsible for charges not covered or reimbursed by my insurance. I agree, in the event of non-payment, to assume the costs for interest, collection, and legal action (if required).

Initials _____

I understand I have the right to request and receive a Notice of Privacy Practices from Capital Cardiology Associates.

Initials _____

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Capital Cardiology Associates to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit and view as necessary for my care and treatment.

Initials _____

Patient Signature_____ Date _____

Parent/Guardian _____ Date _____