DEARBORN CARDIOLOGY

New Patient Registration & History

Patient Name: _____

Date of Birth: _____

Address: _____

Marital Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced

Social Security: _____

Please circle contact preference

Home Phone: _____ **Cell:** _____

Race: _____ **Ethnicity:** _____

Emergency Contact _____ **Telephone:** _____

Relationship: _____

Referring Physician _____

Primary Physician _____

Pharmacy: _____ ***Location:*** _____

Employer: _____ **Work Number:** _____

Insurance Information:

Primary Insurance:
Address:
Subscriber Name:
DOB: **Sex:**
Relation To Patient :
Subscriber ID: **Group Number:**

Secondary Insurance: **Phone Number:**
Address:
Subscriber Name: **DOB:** **Sex:**
Relation To Patient :
Subscriber ID: **Group Number:**

Please note it is the responsibility of the patient to obtain referrals for treatment.
If you have Blue Care Network you MUST have a Global referral before evaluation with specialist.

Financial Policy / Insurance Authorization/Assignment of Benefits

I request that payment of authorized Medicare/or any third-party benefits be made to or on my behalf to Elias H. Kassab M.D. PC, for any services furnished to me by one of its providers. I authorize any holder of information about me to the Centers for Medicare/Medicaid Services and its agents or any third-party payer any information needed to determine these benefits or the benefits payable for related services

The undersigned acknowledges that he/she has received a detailed copy of the financial, insurance authorization and assignment of benefits policy.

_____ _____

Signature **Date**

HIPAA Consent

Please indicate if there is a friend or family member to whom we are allowed to release medical information to:

Name: _____ Relationship _____

Name: _____ Relationship _____

*You may also identify a friend or family member to whom we are specifically **restricted** from releasing medical information to:*

Name: _____ Relationship _____

The undersigned acknowledges that he/she has received a detailed copy of the notice of privacy practices.

_____ _____

Signature **Date**

Rx History Consent

I give permission for my provider to access my pharmacy benefits data electronically through RxHub.

The undersigned acknowledges that he/she has received a detailed copy of Rx history consent.

_____ _____

Signature **Date**

Permission to Communicate my Health Information Electronically

PLEASE INDICATE YOUR CHOICE
TO PARTICIPATE OR NOT IN THE EXCHANGE AS PROVIDED FOR BELOW.

_____ YES, I want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange.

_____ NO, I do not (or no longer) want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange.

The undersigned acknowledges that he/she has received a detailed copy of the health information exchange.

_____ _____

Signature **Date**

MEDICATION LIST *Please complete or provide a paper copy of your own list.*

Medication Name (Include over the counter medication)	Strength / Dose (mg)	Number of pills per dose	Number of times Per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Past Medical History

Diabetes	____ Yes	___ No		Mental Illness	____ Yes	___ No
High Blood Pressure	____ Yes	___ No		Dementia (Alzheimer's etc.)	____ Yes	___ No
Stroke	____ Yes	___ No		Seizures	____ Yes	___ No
Heart Disease / Heart Attack	____ Yes	___ No		Cancer	____ Yes	___ No
High Cholesterol	____ Yes	___ No		• Cancer Type		
Thyroid Disease	____ Yes	___ No		Cardiomyopathy	____ Yes	___ No
(PVD) Vascular Disease	____ Yes	___ No		CHF Congestive Heart Failure	____ Yes	___ No
Bleeding Disorder	____ Yes	___ No		Atrial Fibrillation	____ Yes	___ No
Emphysema / COPD	____ Yes	___ No		Other:		
Liver Disease	____ Yes	___ No				
Rheumatic Fever	____ Yes	___ No				
Asthma	____ Yes	___ No				
Ulcers	____ Yes	___ No				

Allergies

Drug/Non-Drug Allergy	Allergic Reaction

Cardiac and Vascular History/Procedures

Previous Procedures	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

	Living	Age	Deceased	Age at Death	Medical History (Ex. Diabetes, Stroke, Heart Attack)
Father	☐		☐		
Mother	☐		☐		
Brother(s)	☐		☐		
Sister(s)	☐		☐		
Children	☐ **Sons #** _____		☐ **Daughters #** _____		

Patient Social History

Use of Tobacco:	___Never ___Previously, years quit? ___Current Packs/Day ____
Use of Alcohol:	___Never ___Rarely ___Moderate ___Daily
Use of Drugs:	___Never ___Yes, Type/Frequency_____
Exercise:	___No ___Yes, Type/Frequency_____
Caffeine:	___No ___Yes, Type/Frequency_____