Care Cardiology Associates LLC
Dilip Donde, MD
Sangeeta Garg, MD, FACC

555 Iron Bridge Rd, Suite 15, Freehold, NJ 07728
Tel: (732) 294-9373 Fax: (732) 333-1366

Account Number:

Date:

Patient Information

Please answer all questions fully

Patient					
Name (Last, First, MI)	Social Security #	Age	Date of Birth	Sex	Marital Status
Mailing Address	City	State	Zip code	Home Phone	
Employer	City	State	Zip code	Work Phone	
E-mail Address				Mobile Phone	

Responsible Party					
Name (Last, First, MI)	Social Security #	Age	Date of Birth	Sex	Home Phone
Mailing Address	City	State	Zip code	Marital Status	
Employer	City	State	Zip code	Work Phone	

Emergency Contact Information					
Contact Name	Relationship	Primary Phone Number			Secondary Phone Number

Primary Doctor	**Referring Doctor**	**Referring Doctor Address**	**Phone**	**Fax**

Insurance Information				
Primary Insurance Company	Subscriber's Name, Date of Birth, SSN	Relationship	Policy # /Group #	Copay
Second Insurance Company	Subscriber's Name. Date of Birth, SSN	Relationship	Policy # /Group #	Copay
Third Insurance Company	Subscriber's Name, Date of Birth, SSN	Relationship	Policy # /Group #	Copay

Who may we send our thanks to for referring you here:_____

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims, I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature:_____Date: _____

(Signature of insured or authorized person, patient or parent if minor)

I acknowledge that I have received the HIPPA Notice of Privacy Practices.

Signature:_____Date: _____

New Patient Form

Patient name:_____ **Date:**_____ **Height:**_____**Weight:**_____

Complaint: What is the main reason(s) you are seeking a cardiac/medical evaluation_____

Approximate date of onset:_____

Other associated symptoms:_____

Past Medical History: Please check yes or no.

	Yes	No	Duration			Yes	No	Duration
High blood pressure					Bleeding tendency			
Diabetes					Stroke			
High cholesterol					Thyroid disease			
Heart disease					Cancer			

Other medical problems, prior surgeries and hospitalizations:

Social History: Occupation:_____ Level of education:_____
Living situation:_____
Alcohol: currently_____ past_____ How much?_____
Tobacco: currently_____ previously, but quit (how long ago)_____, packs per day:
Recreational Drugs:_____

Family Medical History: List disease(s) and the family member(s) with the disease(s).

Review of Systems: Please check yes or no | Write down symptoms not listed in the blank rows.

	Yes	No		Yes	No
Chest Pain			Weight loss		
Palpitations			Weight Gain		
Shortness of breath			Weakness in muscles or joints		
Fatigue			Muscle pain / cramps		
Leg edema			Neck or low back pain		
Coughing			Pain In joints		
Fever			Headache / migraine		
Palpitations			Rash		
Dizziness /Lightheadedness			Numbness or tingling sensations		
Nausea / vomiting			Memory loss		
Diarrhea			Trouble walking / gait disturbance		
Constipation			Nervousness / anxiety		
Rectal bleeding or blood in stool			Depression / moodiness		
Frequent urination			Insomnia		
Blood in urine			Excessive thirst or urination		
Incontinence or dribbling			Heat or cold intolerance		
Snoring					
Other symptoms:					

Allergies:

Current Medications: Please list dose and frequency if possible.

Pharmacy	**Address**	**Phone**	**Fax**

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IN THE EVENT MY PHYSICIAN SHOULD NEED MY MEDICAL RECORDS FROM A HOSPITAL OR ANOTHER MEDICAL OFFICE, I HEREBY GIVE MY AUTHORIZATION TO HAVE THIS INFORMATION RELEASED TO:

Care Cardiology Associates LLC
Dilip Donde, MD
Sangeeta Garg, M.D. FACC

Name:____**D.O.B.**________________________________

Signature:____

Doctor/Hospital:____

Date:____

REOUESTOR/RECIPIENT INFORMATION

Please disclose following protected health information to Care Cardiology Associates, LLC

______All records in your possession,

______This request is for the purpose of____

____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above name facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six month or on this date listed __________.

l understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that *I* need not sign this authorization to assure treatment. I understand that I may impact and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary, I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility list above that is authorized to disclose thus information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to:
____treatment of drug_________________________**____alcohol abase**
____mental health________________________________**acquired immunodeficient syndrome (AID)**
____human immunodeficiency virus (HIV)_________**____sexually transmitted diseases**
tuberculosis information **genetics**

THIS INFORMATION WILL ALSO BE RBLEASED UNLESS YOU INDICATE; NO, DO NOT RELEASE: Indicate with a check mark.

Signature:__________________________________Date: ____

Representative Authority to act on behalf of patient ____

Signature of Witness: ____