COR HEALTHCARE MEDICAL ASSOCIATES

Appointment Date & Time: **PATIENT REGISTRATION**

PATIENT INFORMATION

Patient #:	Gender:	Date of Birth: Age:
Last Name:		PCP:
First Name: Middle Initial:		Social Security #:
Marital Status:	__ Single __Married __Widow	Ethnicity: ____Hispanic ____Non-Hispanic ___Refused
Race: Please check one of the following: ____White ____Black/African American ____Asian ____Refused to Report ___Native Hawaiian or other Pacific Islander ____American Indian/Alaska Native		Preferred Language: ____English ____Spanish Other: _____
Address:		Home Phone: Cell Phone:
City, State, Zip:		Email:

EMPLOYMENT INFORMATION

Employer:	**Retired:** Retirement Date: _____
Address:	**Please check the following:**
City:	Disabled: **Yes** _____ **No** _____
State, Zip:	Unemployed: **Yes** _____ **No** _____
Work Phone:	

INSURANCE INFORMATION

Primary Insurance:		Insured Policy:	
Address:		Insured Policy ID:	
City, State, Zip:		Group Number:	
Plan Phone:		Date of Birth:	
Effective Dates:		Patient Relationship to Subscriber:	
Second Insurance:		Insured's Name::	
Address:		Insured Policy ID:	
City, State, Zip:		Group Number:	
Plan Phone:		Date of Birth:	
Effective Dates:		Patient Relationship to Subscriber:	

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Patient's Relation to Contact:
Contact Home Phone:	Contact Cell Phone:
Contact Work Phone:	

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize Cor Healthcare Medical Associates to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges., I hereby authorize Cor Healthcare Medical Associates to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

X_____ Date:_____

Signature

COR Healthcare Medical Associates
Patient's Personal History

Date: _____

Name: _____ Date of Birth: _____

How would you like us to address you? _____

Age: _____ Height: _____ Weight: _____ Occupation: _____

Referring Physician: _____ Date of last exam: _____

Why are you here today? _____

PAST MEDICAL HISTORY: (Please check any of the following problems that apply to you)

- ☐ Heart Attack
- ☐ Angioplasty/ Stent
- ☐ Heart Surgery
- ☐ Peripheral Atherosclerosis Disease
- ☐ Stroke/ TIA
- ☐ Arrhythmia/ Irregular Heart Beat
- ☐ Valvular Heart Disease
- ☐ Congenital/ Rheumatic Heart Disease
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes Mellitus
- ☐ Thyroid Disorder
- ☐ Anemia
- ☐ Cancer
- ☐ Gastric Ulcer/ Heartbeat
- ☐ Asthma/ COPD
- ☐ Kidney Disease

Vaccines	Date
☐ Flu:	_____
☐ Pneumonia:	_____
☐ Shingles:	_____
☐ Colonoscopy:	_____

For Women Only

- ☐ Pap Test: _____
- ☐ Mammogram: _____

PAST SURGICAL HISTORY: (Include Dates)

_____ ___/___/___

_____ ___/___/___

ALLERGIES: (List food and/or medication)

_____

MEDICATIONS: (Include Vitamins, herbal supplements, over-the-counter meds. etc.)

Medication	Dose	Frequency

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Widow

Do you have any children? ☐ Yes ☐ No How many? _____ Any major illnesses? _____

Have you ever used tobacco products? ☐ Yes ☐ No

If yes, how long? _____ How much? _____ Quit Date: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind/ how much per day? _____

Do you, or have you used recreational drugs? ☐ Yes ☐ No If yes, what type? _____

Do you drink caffeine daily? ☐ Yes ☐ No If yes, how many cups do you drink daily? _____

Do you exercise outside of your job? ☐ Yes ☐ No If yes, what kind/ how often? _____

FAMILY HISTORY: (Check the appropriate boxes)

	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brothers/ Sisters	Other
High Blood Pressure/ Hypertension						
Heart Attack/ Heart Surgery						
Diabetes						
Stroke						
Cancer (Type/ Location)						
Osteoporosis						
Thyroid Problems						

REVIEW OF SYSTEMS: (Please check any of the following problems that apply to you)

Constitutional
- ☐ Weight loss/ gain
- ☐ Fatigue/ lethargy

Head and Neck
- ☐ Headache
- ☐ Dizziness/ fainting
- ☐ Eye disease/ glaucoma
- ☐ Blurred/ double vision
- ☐ Decreased hearing
- ☐ Sinus trouble
- ☐ Trouble swallowing
- ☐ Numbness or weakness in arm or leg

Respiratory
- ☐ Asthma/ wheezing
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Cough up blood/ sputum

Cardiovascular
- ☐ Chest pain/ pressure/ tightness
- ☐ Palpitations/ Irregular heart beat
- ☐ Swollen ankles
- ☐ Shortness of breath when lying down
- ☐ Shortness of breath with exertion
- ☐ Angioplasty/ Stent: When? _____
- ☐ CABG: When? _____

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Heartburn/ indigestion
- ☐ Nausea/ vomiting
- ☐ Abdominal pain
- ☐ Diarrhea/ constipation
- ☐ Bloody or black stools

Genitourinary
- ☐ Frequent need to urinate
- ☐ Burning or painful urination
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Swelling in hands and feet

Neurology
- ☐ Memory loss
- ☐ Numbness/ weakness of arm or leg

Musculoskeletal
- ☐ Varicose veins
- ☐ Pain in big toe/ Gout
- ☐ Pain in calves/ hips when walking
- ☐ Pain in joints

Gynecological
Women Only:
- ☐ Postmenopausal
- ☐ Taking hormone replacement therapy

Male Only:
- ☐ Loss of sexual activity
- ☐ Taking Viagra/ Cialis/ Levitra

_____ _____

Patient's Signature **Date**

COR HEALTHCARE MEDICAL ASSOCIATES

HIPAA (Health Insurance Portability & Accountability Act)

Authorization for use and disclosure of Medical Information

In compliance with the HIPAA Patient Policy, this authorization allows COR Healthcare Medical Associates to release any of your protected medical information to the designated individual that you have specified.

I hereby authorize: COR Healthcare Medical Associates to release my medical information regarding my medical history and treatment by means of verbal communication in person, via telephone and/or mail and fax to the persons listed below.

1. _____( ) _____
   Phone Number
2. _____( ) _____
   Phone Number
3. _____( ) _____
   Phone Number

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

___ Home Telephone: ( ) _____
- ___ Leave message with detailed information on answering machine device, or anyone who answers
- ___ Leave message with a call back number only.

___ Work Telephone: ( ) _____
- ___ Leave message with detailed information on answering machine device, or anyone who answer.
- ___ Leave message with a call back number only.

___ Cell Number: ( ) _____
- ___ Leave message with detailed information on voice mail or anyone who answers.
- ___ Leave message with a call back number only.

___ Written Communication
- ___ Mail to my home address.
- ___ Mail to: _____

_____

___Other/**FAX:** ( )_____

Patient Name: **D.O.B:** **Date:**

I have been advised of my right to receive a copy of this authorization. A photocopy or fax of this authorization shall be considered as effective and valid as the original.
I understand this authorization will be in effect until which time it is revoked.

_____ _____
Signature of Patient or legal/personal representative Relationship

COR HEALTHCARE MEDICAL ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date:

Patient Name: D.O.B.:

Patient Telephone Number: ( ) _____

I hereby authorize the following medical information to be released, which may include any information relating to cardiac, physical history, condition, advice or treatment.

Please furnish dates of specific records required: _____

_____

FROM:
Name: _____

Address/City/State/Zip: _____

_____

Telephone Number:_____

TO:
Name: _____

Address/City/State/Zip: _____

_____

Telephone Number:_____

Signature: _____Date:_____
Authorization Expires One Year from the Signed Date