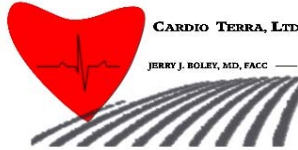
PATIENT REGISTRATION FORM

CARDIO TERRA, LTD
4112 MONROE ROAD
CELINA, OH 45822-9250
567-890-9000 PHONE#
567-890-9009 FAX#
WWW.CARDIOTERRA.COM



OFFICE USE ONLY

PS Acct#_______________

PATIENT INFORMATION

NAME (FIRST)______________________________(MI)_____(LAST)____
DATE OF BIRTH__________________ AGE______ SEX M___F___MARITAL STATUS S/M/W/D
ADDRESS______________________________________ CITY, STATE, ZIP_____________________________________
SS#__________________________HOME PHONE_________________________WORK#________________________
CELL# _________________EMAIL____________________________EMPLOYER______________________________
ADDRESS__________________________________CITY, STATE, ZIP____
REFERRING PHYSICIAN______________________________________PHONE________________________________
PRIMARY CARE PHYSICIAN (if different from above)____
PREFERRED PHARMACY____

RESPONSIBLE PARTY OR SPOUSE INFORMATION

FULL NAME________________________________DOB_______________RELATIONSHIP TO PT: Self/Spouse/Depend.
ADDRESS____
CITY, STATE, ZIP____
HOME PHONE_________________________________WORK PHONE____________________________________
CELL PHONE__________________________________SS#____
EMPLOYER___________________________________ADDRESS______________________________________
CITY, STATE, ZIP____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME____PHONE____________________________
INSURANCE ADDRESS____
CITY, STATE, ZIP____
POLICY/I.D.#______________________________________GROUP#______________________________________
INSURED'S NAME______________________________DOB________________RELATIONSHIP TO PT: Self/Spouse/Depend.
INSURED'S EMPLOYER___________________________PHONE#____
EMPLOYER'S ADDRESS____
INSURED'S SS#___________________________________DATE OF BIRTH_________________ SEX M____F_____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME____PHONE_____________________________
INSURANCE ADDRESS____
CITY, STATE, ZIP____
POLICY/I.D.#______________________________________GROUP#_______________________________________
INSURED'S NAME_______________________________ DOB________________RELATIONSHIP TO PT: Self/Spouse/Depend.
INSURED'S EMPLOYER___________________________PHONE#____
EMPLOYER'S ADDRESS____
INSURED'S SS#____________________________________DATE OF BIRTH_________________ SEX M_____F_____

I hereby assign, transfer, and set over to CARDIO TERRA, LTD all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

PATIENT'S SIGNATURE:____DATE:________________________________

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-192), 42 U.S.C. Section 1320d, et seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Cardio Terra, Ltd will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use of disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Cardio Terra, Ltd may use or disclose your medical information to other healthcare providers involved in your care and for treatment, payment and healthcare operations.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Cardio Terra, Ltd's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Cardio Terra, Ltd has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Cardio Terra, Ltd by sending a written request with return address to Privacy Manager 4112 Monroe Rd Celina, OH 45822-9250.

In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your PHI in the designated record set maintained by Cardio Terra, Ltd for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Cardio Terra, Ltd has taken action in reliance on it. A revocation is effective upon receipt by Cardio Terra, Ltd of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: a) revocation of the authorization, b) a finding by the Secretary of the US Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Cardio Terra, Ltd, or d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Cardio Terra, Ltd will provide the patient, upon request, with a copy of this authorization.

Acknowledged and agreed to by: PATIENT NAME:____________________________________

____ ______________________

Patient Signature or Authorized Representative Date

May we leave messages at home with other residents	yes ◯	no ◯
May we leave personal health information on your answering machine/voicemail	yes* ◯	no ◯
May we contact you via e-mail or cellular telephone	yes** ◯	no ◯
May we contact you via text message	yes** ◯	no ◯

*Appointment reminders will be left on voicemail.

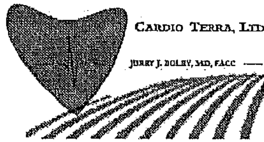
**We cannot ensure the confidentiality of information shared by these means.

Please list the names of all individuals with whom we may talk to about your medical concerns: Please note, that we will not release any personal health information to anyone unless they are listed.

Name____________________________Relationship_________________________Phone#______________________

Name____________________________Relationship_________________________Phone#______________________

Name____________________________Relationship_________________________Phone#______________________



OFFICE USE ONLY

PS Account#______________

CONSENT TO RELEASE PERSONAL HEALTH INFORMATION (PHI)

I give permission to release the health information of:

PATIENT NAME:____**DOB:**__________________________

STREET ADDRESS:__________________________________**LAST 4 DIGITS OF SSN:**_______________

CITY, STATE, ZIP__________________________________**TELEPHONE: (   )**____________________

EMAIL ADDRESS____

Release Information **FROM:**	Release Information **TO:**
______________________	CARDIO TERRA, LTD
(Name of Practice/Facility/Person/Physician)	(Name of Practice/Facility/Person/Physician)
______________________	4112 MONROE RD
Street Address	Street Address
______________________	CELINA, OH 45822-9250
City, State & Zip	City, State & Zip
______________________	567-890-9000 567-890-9009
Phone number Fax Number	Phone number Fax Number

Purpose of Release (check reason): X Request of individual/personal _____Continued patient care

____Insurance____Legal purpose including discussions and proceedings ____Other__________________________

Treatment dates FROM______________________**TO**__________________________

HOSPITAL SUMMARY: Includes history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies. **OFFICE/CLINIC SUMMARY:** May include most recent office visits, physical exam, consults, and diagnostic test results.

HOSPITAL (check all that apply)

- ○ Hospital Summary
- ✓ Discharge Summary
- ✓ H&P
- ○ Operative Report
- ✓ Lab Report
- ✓ Radiology/X-Ray Report
- ○ Pathology Report
- ✓ Cardiac Reports/EKG

Other____________________________ __________

PLEASE SEND ONLY MOST RECENT ADMISSION AND MOST RECENT HEART CATH OR HEART TESTING RESULTS

OFFICE/CLINIC (check all that apply)

- ✓ Office/Clinic Summary
- ✓ Office Visits
- ✓ Physical Exam
- ✓ Consult Report
- ✓ Lab Report
- ✓ Radiology/X-Ray Report
- ✓ Cardiac Reports/EKG

PLEASE SEND ONLY THE LAST 2 OFFICE NOTES AND MOST RECENT TESTING RESULTS.

PATIENT'S RIGHTS-I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- My health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I can refuse to sign this authorization. I need not sign this in order to assure treatment.
- Any disclosure of information carried with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

This permission expires one year after the date of my signature unless another date or event is written here:______________________________

SIGNATURE:______________________________

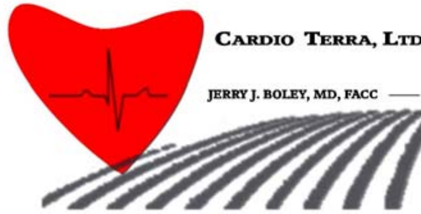
PRINT NAME:______________________________

DATE:______________________

If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

- ◯ HEALTHCARE AGENT/POA
- ◯ ADULT CHILD
- ◯ EXECUTOR/ADMINSTRATOR/ATTORNEY OF FACT
- ◯ SPOUSE
- ◯ AFFIDAVIT NEXT OF KIN
- ◯ OTHER

Cardio Terra, Ltd
4112 Monroe Road
Celina, OH 45822-9250
567-890-9000 Phone
567-890-9009 Fax



OFFICE USE ONLY

PS Acct#_______________

ADULT PATIENT HISTORY FORM

NAME:_________________________________**DOB:**____________________**DATE:**____________________

Marital Status: M/S/W/D **Occupation:**____________________**Employer:**__________________________

Do you or have you ever smoked? Y/N **If yes, how much?**______**how long?**________

Do you drink alcoholic beverages? Y/N **If yes, how much?**_______**per day?**_____**week?**_____

Do you consume caffeine? Y/N **If yes, how much?**_______**per day?**_____**week?**_____

Do you exercise regularly? Y/N If yes, what type of exercise?____________________**how often?**__________

PAST MEDICAL HISTORY: Please list any medical conditions for which you have been treated in the past.

Medical Condition	Date of Onset	Medical Condition	Date of Onset
1		2	
3		4	
5		6	
7		8	
9		10	

PAST SURGICAL HISTORY: Please list any surgeries that you have had along with the date of the surgery.

Surgery/Procedure	Date	Surgery/Procedure	Date
1		2	
3		4	
5		6	

MEDICATIONS: Please list all medications you are taking, including over-the-counter medications and herbal supplements. Please include dose and frequency.

Medication	Dose	Freq.	Medication	Dose	Freq.
1			**2**		
3			**4**		
5			**6**		
7			**8**		
9			**10**		
11			**12**		
13			**14**		

NAME:________________________________DOB:____________________DATE:___________________

ALLERGIES: If you have no known drug allergies, please check this box ☐

Please list all medications you are allergic to and what occurs/has occurred when you take that medication.

Allergic Medication	Reaction	Allergic Medication	Reaction
1		2	
3		4	
5		6	

FAMILY HISTORY: For each of the following family members, please list their age (or age at death), if known and any illnesses including: diabetes, high blood pressure, heart disease, cancer, kidney problems, liver problems, lung problems, depression, allergies or arthritis.

MOTHER	FATHER
SIBLINGS	CHILDREN

IF YOU HAVE A CARDIAC DEVICE, PLEASE COMPLETE THE FOLLOWING:

Implanted Cardiac Device: Pacemaker____ ICD (Implantable Cardioverter Defibrillator___ Other____________

Company of implanted device: Boston Scientific (Guidant)___ Medtronic___ St. Jude Medical___ Other___

Implanting physician_________________________ Following physician_____________________________

Date of last device follow up appointment performed in the office_______________ remotely____________

Would you like to transfer device follow up care to Cardio Terra, Ltd? _____YES _____NO

PLEASE BRING YOUR DEVICE ID CARD WITH YOU TO YOUR APPOINTMENT SO THAT WE CAN MAKE A COPY FOR OUR RECORDS. Thank you.

NAME:____________________________________**DOB:**______________________**DATE:**_____________________

REVIEW OF SYSTEMS: Please check if you have been experiencing any of the symptoms below within the last 6 months:

GENERAL: fever____ chills____ headaches____ night sweats____unexplained weight loss/gain____ fatigue____ appetite changes____

EYES: eye pain with sunlight____ vision changes____ redness____ discharge____ pain____ itching____ glasses____ glaucoma____ cataracts____

EARS/NOSE/THROAT: hearing loss____ ringing in ears____ nosebleeds____ runny nose____ nasal congestion____ earache____ post nasal drip____ sore throat____ mouth sores____ dentures____

HEART: palpitations____ leg swelling____ passing out____ leg pain while walking____ chest pain____ difficulty breathing at night____

LUNGS: cough____ coughing up blood____ shortness of breath____ wheezing____ coughing up phlegm____

GI: belly pain____ nausea____ vomiting____ diarrhea____ constipation____ bloody stools____ dark stools____ heartburn____ trouble swallowing____

URINARY TRACT: pain with urination____ blood in urine____ sudden urge to urinate____ decreased stream____ urinating more frequently____ incontinence____

MUSCULOSKELETAL: joint pain____ stiffness____ weakness____ joint swelling____ back pain____ muscle pain____ muscle cramps____

SKIN: itching____ redness____ hair loss____ nail change____ rash____ moles____ dry skin____

NEUROLOGIC: memory loss____ numbness____ difficulty walking____ difficulty speaking____ dizziness____ tremor____

PSYCHIATRIC: depression____ suicidal thoughts____ homicidal thoughts____ hallucinations____ mood changes____ anxiety____ sleep disturbance____

ENDOCRINE: hot/cold intolerance____ hair changes____ increased urination____ increased thirst____

HEMATOLOGY: anemia____ easy bruising____ bleeding of skin/gums____ swollen glands____

ALLERGY/IMMUNE SYSTEM: frequent infections____ breathing difficulties when exposed to allergens____ environmental allergies____

PLEASE SIGN AND DATE BELOW:

PATIENT SIGNATURE:______________________________________**DATE:**____________________________

PHYSICIAN SIGNATURE:____________________________________**DATE:**____________________________

Cardio Terra, Ltd
4112 Monroe Road
Celina, Oh 45822

Phone 567-890-9000
Fax 567-890-9009