Auburn Cardiology Associates
PATIENT INFORMATION SHEET

Patient Name _____ Date of Birth _____/_____/_____

Street Address _____

City _____ State _____ Zip _____

Telephone: Home#_____ Cell#_____ Work#_____

Email: _____ Marital Status: S ____ M ____ W ____ Div ____ Sep ____

Spouse or Guardian's Name _____

Patient's Employer _____ Occupation _____

Who is your Medical Doctor?_____

Emergency contact: 1ST _____ Tele # _____

2nd _____ Tele # _____

INSURANCE INFORMATION

PRIMARY Insurance _____ ID# _____

Subscriber if other than patient:

Insured's Name _____ Date of Birth _____/_____/_____

SECONDARY Insurance _____ ID# _____

Subscriber if other than patient:

Insured's Name _____ Date of Birth _____/_____/_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Rama M. Godishala, M.D., P.C. I also authorize my physician to release any information acquired in the course of my examination and/or treatment.

Date _____/_____/_____ **Signature** _____

CONSENT FOR CARE

I hereby grant Dr. Rama M. Godishala/Dr. Baker/Dr. Agno permission to make such investigations and give such treatments on myself, as they deem necessary or advisable.

Date _____/_____/_____ **Signature** _____

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS

… That the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any type of medical information about me to release to the Social Security Administration, or it's carriers, any information required to process my Medicare claims.

… That payment under the Medical Insurance Program be made to me or to Rama M. Godishala, M.D., P.C. for services provided to me for the period of the date of onset to life.

Medicare Beneficiary's Signature _____ **Date** _____/_____/_____

New Patient History Form

Patient Name_____ DOB_____ Today's Date_____

Reason for today's visit (cc)_____

Current Medications (include over the counter and vitamins):_____

Check areas below that relate to your current health status:

Review of Systems	Yes	No	Comment / Explanation
General Health (Do you feel well?)	☐	☐	
Heartburn, belching, nausea, bloated stomach, or difficulty swallowing? If yes please explain.	☐	☐	
Change in bowel habits?	☐	☐	
Loss of appetite? More than 5 pound weight change in last year.	☐	☐	
Abdominal pain, pressure or discomfort?	☐	☐	
Urinary problems (pain, burning or frequency)? Incontinence?	☐	☐	
Headaches, dizziness, loss of consciousness, or poor memory?	☐	☐	
Chest pain or shortness of breath, at rest or with exertion? Irregular or pounding heartbeat?	☐	☐	
Difficulty breathing, cough, or lung congestion?	☐	☐	
Changes in eye sight or eye pain?	☐	☐	
Loss of hearing? Ear or sinus pain? Ringing or buzzing in ears?	☐	☐	
Changes on self breast exam?	☐	☐	
Rash, skin discoloration or changes in birthmarks or moles?	☐	☐	
Bruising or bleeding?	☐	☐	
Bone or joint pain, muscle aches or loss of strength?	☐	☐	
Increased thirst, fatigue, loss of hair or dry skin	☐	☐	
Swelling in neck, armpit or groin?	☐	☐	
Depression or anxiety? Trouble sleeping?	☐	☐	
Allergies (food, drug or environmental)	☐	☐	
Do you: Smoke? Drink alcohol? Use drugs? Drink caffeine?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Do you feel safe in your home environment?	☐	☐	

Social History: M D W S Other:_____
Living alone? ☐ NO ☐ Yes Explain:_____

Past Health History

Please list any hospitalizations or operation you have had. Include one-day surgeries.

DATE	TYPE OF ILLNESS OR SURGERY	NAME OF HOSPITAL	LOCATION OF HOSP

Patient Name:_____ Date:_____

Check box if you have NOW or have ever had any of the following conditions/illnesses:

☐ Cancer: Type_____		☐ Diabetes	☐ Osteoporosis	☐ Unexplained fevers
☐ Stroke	☐ Liver disease	☐ Arthritis	☐ Prolonged fatigue	☐ Tuberculosis
☐ Mononucleosis	☐ Gout	☐ Abnormal chest x-ray	☐ Chronic Bronchitis	☐ Kidney Disease
☐ Seizures or Epilepsy	☐ Rheumatic fever	☐ Asthma	☐ Kidney Stones	☐ Depression
☐ Heart Murmur	☐ Chronic Lung Disease	☐ Prostate Disease	☐ Anxiety/Panic Attacks	
☐ Heart Attack	☐ Pneumonia	☐ Infertility	☐ Thyroid Disease	
☐ Heart Disease	☐ Stomach ulcers	☐ Venereal Disease (Sexually Transmitted Disease)		
☐ High Blood Pressure	☐ Hepatitis	☐ Blood, albumin (protein) or sugar in urine		

Last Echocardiogram:(date)_____at(place)_____by(ordering MD):_____
Last EKG: :(date)_____at(place)_____by(ordering MD):_____
Last Stress Test: :(date)_____at(place)_____by(ordering MD):_____

Family Health History

	Age	Present health, or if deceased, cause of death	Age at death
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

Please place the appropriate letter in space to indicate if blood relatives have/ or had any of the following problems:
M—mother **F**—Father **S**—Sister **B**—Brother **G**—Grandparent **C**—Children

Heart Disease: _____ **Congestive Heart Failure (CHF)** ____ **Heart Attack** _____**Stent or Bypass Surgery**

_____Leukemia	_____Crippling arthritis	_____Suicide attempt	
_____Stroke	_____Lung Cancer	_____Lupus	_____Nervous Breakdown
_____High Blood Pressure	_____Cervical Cancer	_____Glaucoma	_____Gout
_____High Cholesterol	_____Breast Cancer	_____Diabetes	_____Thyroid problems
_____Sudden death	_____Uterine Cancer	_____Alcoholism	_____Seizures/Fits
_____Bleeding Disorder	_____Colon Cancer	_____Nervous Disorder	_____Epilepsy
_____Sickle cell disease	_____Cancer (other)	_____Depression	_____Kidney disease

Immunizations

Please indicate the year of your most recent immunization:

Tetanus		**Measles/Mumps/ Rubella**	
Influenza (Flu Shot)		**Hepatitis B**	
Pneumonia (Pneumovax)		**Tuberculin Test (PPD)**	

Signature of Patient _____ Date:_____

Reviewed By _____ Date_____