NORTHSIDE CARDIOLOGY, P.C.
TESTING LAB
PATIENT MEDICAL HISTORY INFORMATION SHEET

NAME _____ SEX _____ DATE _____

PHONE _____

SS# _____ DOB_____ AGE _____

EMAIL ADDRESS _____

HEIGHT _____ WEIGHT _____ REFERRING PHYSICIAN _____

REASON FOR TEST _____

MEDICATION ALLERGIES _____

CURRENT MEDICATION	DOSAGE	FREQUENCY (HOW OFTEN)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

You have or have you ever had:

YES	YES
_____ Heart disease or heart attack	_____ Heart valve surgery
_____ Congestive heart failure (fluid in lungs)	_____ Bypass surgery
_____ High blood pressure	_____ Pacemaker / ICD
_____ Irregular heart beat	_____ TIA / stroke
_____ High cholesterol	_____ Difficulty walking
_____ Asthma or other lung disease	_____ Cancer
_____ Diabetes	_____ Breast implants

_____ Chest pain. IF YES, what seems to cause it? _____

What makes it go away?_____

_____ Do you smoke? How much and for how long? _____

_____ Are you pregnant?

_____ Do you drink alcohol? Avg. # of drinks per week_____

_____ Family history of heart problems? If yes, please describe_____

_____

NORTHSIDE CARDIOLOGY, P.C.

PATIENT INFORMATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient's Name: (first- middle- last) Date _____

Mr./Mrs./Ms _____ Date of Birth _____ Age _____

Address _____ Marital Status_____

City _____ State _____ Zip_____ Email Address _____

Home Phone Number _____ Employer _____

Cell Phone Number_____ Address _____

SS# of Patient _____ City _____ State _____ Zip _____

Sex _____ Employer Phone Number _____

Primary Insurance Name _____ Policy # _____

Address _____ Group # _____

_____ Phone # _____

Name of Insured _____ Relationship to Insured _____

DOB of Insured _____ SS# of Insured _____

Secondary Insurance Name _____ Policy # _____

Address _____ Group # _____

_____ Phone # _____

Name of Insured _____ Relationship to Insured _____

DOB of Insured _____ SS# of Insured _____

Emergency Contact:

Name _____ Phone # _____ Relationship _____

Address _____ City/State/Zip _____

*****Very Important to Fill Out Below*****

Referring Physician _____ _____ **Phone** _____

First Name Last Name

Primary Care Physician _____ _____ **Phone** _____

First Name Last Name

PREFERRED METHOD OF PAYMENT (check one): □Check □ Cash □ Credit Card

NorthsideCardiology

COMMUNICATION AUTHORIZATION FORM

Jack Chen, MD Nabeel Hafeez, MD Mohammad Kooshkabadi, MD
Michael Balk, MD Marcus Brown, MD

Patient's Last Name: _____ First Name: _____

Date of Birth: _____ SS#: _____ Sex: Male / Female

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: _____ Marital Status: Single / Married / Divorced / Widow / Separated

Employment Status: Full Time / Part Time / Unemployed Work Phone #: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Referring Physician: _____ Family Physician: _____

I authorize physicians and staff of Northside Cardiovascular Care and Prevention Center to communicate and/or leave messages for me at the following locations:

	Calling OK?	Messages OK?	Phone Number	Order of Preference
HOME	Yes / No	Yes / No		
CELL	Yes / No	Yes / No		
WORK	Yes / No	Yes / No		

Persons authorized to receive information about my healthcare:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Emergency Contacts:	CONTACT #1	CONTACT #2
Name:	_____	_____
Relationship:	_____	_____
Preferred Phone:	_____	_____
Second Phone:	_____	_____
Third Phone:	_____	_____

I acknowledge that this authorization can only be amended or rescinded by my written authorization

Signature: _____ Date: _____

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How did you hear about our practice?

- ☐ My primary care physician
- ☐ Family member or Friend (word of mouth)
- ☐ The Radio
- ☐ Up in Cumming Magazine
- ☐ Forsyth Living Magazine
- ☐ Khabar Magazine
- ☐ Metro Atlanta Yellow Pages
- ☐ Chinese Yellow Pages
- ☐ China Journal Atlanta
- ☐ Internet Search Engine
- ☐ I saw Dr._____ give a talk/education session
- ☐ Other:_____