Patient Profile

Doctor: ____________________

PATIENT INFORMATION

Name: ____________________

Address: ____________________

____

City-State: ____________________

Phone: ____________________ [ ] Home [ ] Work [ ] Other

Phone: ____________________ [ ] Home [ ] Work [ ] Other

Patient ID #: ____________ Sex: [ ] M [ ] F

Date of Birth: ____________________

Social Security #: ____________________

Marital Status: [ ] Married [ ] Single [ ] Divorced

Referring Physician: ____________________

Primary Physician: ____________________

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Unemployed [ ] Other

Phone: ____________________

Employer: ____________________

CONTACTS

____

____

____

GUARANTOR

[ ] Same as Patient

Name: ____________________

Address: ____________________

____

City,State: ____________________

EMPLOYMENT

Employer: ____________________

Phone: ____________________

Phone: ____________________

Social Security #: ____________________

Date of Birth: ____________________

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: ____________________

Insured Phone: ____________________

Company: ____________________

Relationship to Patient: ____________________

Social Security #: ____________________

Insured ID: ____________________

Policy Group: ____________________

Date of Birth: ____________________

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: ____________________

Insured Phone: ____________________

Company: ____________________

Relationship to Patient: ____________________

Social Security #: ____________________

Insured ID: ____________________

Policy Group: ____________________

Date of Birth: ____________________

I understand that I am receiving medical services from this office under the provisions of my insurance plan. I will be financially responsible for all deductibles, copays and co-insurances under the terms of my insurance contract. If my insurance plan requires a valid referral to receive medical care, I understand that it is my responsibility to provide such referral. If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balances on my account. If my insurance plan is not accepted by this office or is of the 'indemnity' type, I understand that I am financially responsible for all balances remaining after payment of insurance benefits. I herby authorize and assign directly to Suffolk Heart Group, LLP, all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Privacy Notice: The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it . Accordingly, we have provided you with a notice that tells you how Suffolk Heart Group uses and shares your medical information. We also describe your rights and tell you how to get access to your information. This notice also informs you of certain duties Suffolk Health Group has regarding the use and disclosure of medical information. Please sign below acknowledging your receipt and understanding of Suffolk Heart Group's privacy notice(s).

Signature:____________________ **Print:**____________________

SUFFOLK HEART GROUP, LLP

MEDICAL HISTORY FORM

Name: ______________________ DOB: ______________ Date: ______________

Family Physician: ______________________

Chief Complaint: ______________________ Date of Onset: ______________

HISTORY OF PRESENT ILLNESS:

Does this pain/problem occur at a specific time? ______________________

What other signs or symptoms are you having? ______________________

Do you have any kidney disorders? ______________________

Are you allergic to (please circle) DYES SHELLFISH BEE STINGS?

Are you allergic to any medications? List: ______________________

____

PLEASE LIST ALL MEDICATIONS YOU TAKE ______________________

____

____

Have you ever had: ☐ CATH ☐ STENT ☐ BYPASS ☐ VALVE

☐ PACEMAKER ☐ DEFIBRILLATOR ☐ CARDIOVERSION ☐ ABLATION

If so: Date ______________ Hospital ______________ Dr. ______________

Previous Surgeries ______________________

____

PAST MEDICAL HISTORY
(Circle YES or NO for all)

Diabetes	YES	NO
Hypertension	YES	NO
Cancer	YES	NO
What Kind ______________		
Stroke	YES	NO
Heart Trouble	YES	NO
Arthritis	YES	NO
Convulsion Seizure	YES	NO
Bleeding Tendency	YES	NO
Acute Infection	YES	NO
Venereal Disease	YES	NO
Hereditary Defects	YES	NO
Blood Clots	YES	NO

REVIEW OF SYMPTOMS: (check NONE or CIRCLE items)

	NONE	SYMPTOMS
Neurological		headache fainting dizziness seizure numbness tingling weakness
Eyes/Ears/ Nose		vision change double vision pain hearing change ringing in ears smelling changes nose bleeds congestion
Throat		pain difficulty swallowing painful swallowing
Respiratory		cough wheezing pain asthma SOB blood in sputum
Cardiovascular		CP palps irregular heart beat swelling skin/color/temp changes murmur
GI		nausea vomiting blood in stool constipation diarrhea bleeding appetite change weight change pain
GU		frequency hesitancy urgency blood in urine incontinence discharge pain painful urination
Musculoskeletal		swelling limitation of motion pain other
Skin		rash skin change pain itchiness
Psych/ Substance Abuse		history of treatment Out-patient In-patient Over _____ Months ______ Years

PATIENT SOCIAL HISTORY:

What kind of work do you do? ______________________

Marital Status	Single	Married	Separated	Divorced	Widowed
Use of Alcohol	Never	Rarely	Moderate	Daily	Recovering
Use of Tobacco	Never	Previously but Quit	How long ago ________	Current	Pack per day ______
Use of Drugs	Never	Type/Frequency ______________		Recovering	

FAMILY MEDICAL HISTORY:

Father	Heart	Kidney	Cancer	Diabetes	Other
Mother	Heart	Kidney	Cancer	Diabetes	Other
Siblings	Heart	Kidney	Cancer	Diabetes	Other
Spouse	Heart	Kidney	Cancer	Diabetes	Other
Child	Heart	Kidney	Cancer	Diabetes	Other

Other inherited medical problems: ______________________

Completed by: ______________________ Relationship (if other than patient): ______________

Patient Name: ______________________ DOB: ________ Date: ________

PLEASE LIST ALL OF YOUR MEDICATIONS INCLUDING VITAMINS AND SUPPLEMENTS. THIS LIST ALSO SHOULD INCLUDE MEDICATIONS THAT YOU ARE TAKING FOR A SHORT PERIOD OF TIME (ANTIBIOTICS AND STEROIDS).

ALLERGIES TO MEDICATIONS: ________________/________________/________________

NAME OF MEDICATION	DOSAGE	TIMES A DAY

Pharmacy: ____

Address: ____

Phone: ____

Mail Order Prescription Company: ________________________________