PATIENT'S NAME: ____________________ **DOB:** ____/____/____ **SEX:** ☐ MALE ☐ FEMALE
ADDRESS: ____________________ CITY:____________ STATE:______ ZIP:________
PRIMARY PHONE: (______) ________-__________ TEXT: ☐YES ☐NO (data rates may apply)
SECONDARY LINE: (______) ________-__________ TEXT: ☐YES ☐NO (data rates may apply)
VOICEMAILS: ☐NONE ☐ DETAILED ☐RETURN CALL ONLY ☐APPOINTMENT REMINDER ONLY
SSN: ________-______-__________

OCCUPATION: ☐FULLTIME ____________________ ☐RETIRED ☐DISABLED ☐STUDENT
PATIENT EMPLOYER: ____________________ PHONE: (______) ________-__________

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐OTHER ____________
SPOUSE'S NAME: ____________________ DOB: ____/____/____ ☐Patient in the clinic
PHONE: (______) ________-__________ ☐ Also Emergency Contact

EMERGENCY CONTACT:____________________ PHONE: PHONE: (______) ________-__________
RELATIONSHIP:____________
ADVANCED DIRECTIVE (65 & OLDER): ☐N/A ☐Power of Attorney ☐Living Will

PRIMARY CARE PHYSICIAN:____________________ PHONE: (______) ________-__________
REFERRING PHYSICIAN:____________________ PHONE: (______) ________-__________

EMAIL (Needed for patient portal set up): ____________________ @ ____________ . ______
LANGUAGE: ☐ENGLISH ☐SPANISH ☐OTHER ____________
RACE: ☐WHITE ☐AFRICAN AMERICAN ☐ASIAN ☐AMERICAN INDIAN ☐DECLINE
ETHNICITY: ☐NOT HISPANIC ☐HISPANIC ☐DECLINE

PRIMARY INSURANCE: ____________________ PHONE: (______) ________-__________
ID #: ____________________ GROUP #: ____________
SECONDARY INSURANCE: ____________________ PHONE: (______) ________-__________
ID #: ____________________ GROUP #: ____________
PRESCRIPTION INSURANCE:____________________ PHONE: (______) ________-__________
ID #: ____________________ BIN:__________ PCN:__________ GRP: __________

LOCAL PHARMACY: ____________________ PHONE: (______) ________-__________
MAIL ORDER PHARMACY: ____________________ PHONE: (______) ________-__________
Preferred Lab: ☐**Quest** ☐**LabCorp** ☐**Other** ____________________

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT, THE PATIENT IS RESPONSIBLE FOR PAYMENT OF DOCTOR'S FEES WITHIN 30 DAYS REGARDLESS OF INSURANCE COVERAGE OR STATUS OF INSURANCE CLAIMS. EXTENSION OR CREDIT BEYOND 30 DAYS MUST BE APPROVED BY THE BUSINESS OFFICE. CLAIMS WILL BE FILED TO YOUR INSURANCE COMPANY AS A COURTESY TO YOU.

I HEREBY AUTHORIZE NASSER CARDIOLOGY P.A. TO FURNISH INFORMATION TO MY INSURANCE CARRIER(S) CONCERNING MY ILLNESS AND/OR TREATMENT PLANS. I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.

Signature: ____________________ **Date:** ____________________
If you are not the patient, please specify your relationship to the patient:____________________

REASON FOR YOUR VISIT: ____

____

ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?

General
Headache
Lightheadedness
Fatigue
Weight Gain (unexplained)
Weight Loss (unexplained)
Cardiology
Shortness of Breath
Shortness of breath with exertion
Difficulty breathing while lying flat
Chest pain
Chest pain at rest
Chest pain with exertion
Dizziness
Swelling in Feet/Legs
Palpitations

Gastrointestinal
Blood in stool
Heartburn
Hematology
Easy bruising
Prolonged Bleeding
Musculoskeletal
Leg Cramps
Muscle Aches (generalized)
Peripheral/Vascular
Decreased sensation in arms/legs
Pain- Legs/Feet with exertion
Cramping-Legs/Feet with exertion
Pain in Legs/Feet at rest
Cramping –Legs/Feet at rest
Ulceration of legs or feet

Restless leg syndrome
Skin
Blistering of skin
Discoloration of skin
Rash
Neurologic
Balance Difficulty
Difficulty speaking
Fainting
Memory Loss
Loss of vision
Tremor
____
____
____
____

Previous Cardiac Testing

Test	Date	Where
Electrocardiogram (EKG)	Date: ______________	Where: ______________________
Echocardiogram (Ultrasound of Heart)	Date: ______________	Where: ______________________
Stress Test	Date: ______________	Where: ______________________
Holter/Event Monitor	Date: ______________	Where: ______________________
Carotid Artery Ultrasound	Date: ______________	Where: ______________________
Arterial Ultrasound- Legs / Arms	Date: ______________	Where: ______________________
Venous Ultrasound - Legs / Arms	Date: ______________	Where: ______________________

Allergies

☐ **NKDA** – No Known Drug Allergies

Medication: ______________________ Reaction: ______________________
Medication: ______________________ Reaction: ______________________
Medication: ______________________ Reaction: ______________________
Medication: ______________________ Reaction: ______________________
Food: ______________________ Reaction: ______________________
Food: ______________________ Reaction: ______________________

PAST MEDICAL HISTORY

Please circle any of the following disorders that you **HAVE** been diagnosed with

NONE -No history
Atrial Fibrillation
Arrhythmia: ________________
Aneurysm
BPH-Benign prostatic Hyperplasia
CAD-Coronary Artery Disease
Cardiomegaly (Enlarged Heart)
Cancer: ____________________
Carotid Artery Disease
Cardiac Arrest
CKD - Chronic Kidney Disease
Congenital Heart Disease
COPD
COVID -Date________________
Diabetes (Type I/ II)

DVT - Blood Clots in Vein
Endocarditis (infected heart valve)
Erectile Dysfunction
Fibromyalgia
GERD
Heart Attack
Heart Failure
Heart Murmur
Hiatal Hernia
High Cholesterol
Hypertension
Hypogonadism (male)
Migraines
Neuropathy
PAD - Peripheral Artery Disease

PVD - Peripheral Vascular Disease
PE- Pulmonary Embolism
Pulmonary Hypertension
Rheumatic Fever
Seizure Disorder
Sleep Apnea
Stroke or TIA (Mini Stroke)
Substance Abuse Drugs/Alcohol
Thyroid Disease
Varicose Veins
____
____
____
____

Previous Cardiac Procedures

Procedure	Date	Where
Heart Catheterization	Date: ________________	Where:____________________________
Heart Angioplasty/Stent Placement	Date: ________________	Where:____________________________
Coronary Artery Bypass (CABG)	Date: ________________	Where:____________________________
Heart Valve Replacement	Date: ________________	Where:____________________________
Peripheral Artery Angiogram	Date: ________________	Where:____________________________
Peripheral Artery Angioplasty/Stent	Date: ________________	Where:____________________________
Peripheral Artery Bypass	Date: ________________	Where:____________________________
Electrophysiology (EP) Study	Date: ________________	Where:____________________________
Heart Rhythm Ablation	Date: ________________	Where:____________________________
Pacemaker / ICD / ILR Implant	Date: ________________	Where:____________________________
IVC Filter	Date: ________________	Where:____________________________
Varicose Vein Ablation/Stripping	Date: ________________	Where:____________________________
Sclerotherapy	Date: ________________	Where:____________________________
___________________________________	Date: ________________	Where:____________________________

Surgical History

Date	Surgery	Date	Surgery

Hospitalizations

Date	Hospital	Reason

Family History

Relation		Medical History
Father □Healthy	Alive Age _____ Deceased Age____	□Heart Attack □Stroke □Heart Disease □Hypertension □Cholesterol □Diabetes □Cancer □____
Mother □Healthy	Alive Age _____ Deceased Age____	□Heart Attack □Stroke □Heart Disease □Hypertension □Cholesterol □Diabetes □Cancer □____
Siblings □Healthy	Brothers _____ Sisters _______	□Heart Attack □Stroke □Heart Disease □Hypertension □Cholesterol □Diabetes □Cancer □____
Children □Healthy	Son______ Daughters_____	
Paternal Grandparent's	□Healthy	
Maternal Grandparent's	□Healthy	
Other		

SOCIAL HISTORY

Tobacco Use: ☐Never ☐ Currently ☐Former smoker (how long did you smoke): ________________________
If YES, how many Packs/Cigarettes/Cigars per day or week: ☐1/2pk ppd ☐1pk ppd ☐____________
Smokeless Tobacco Type: ☐None ☐Chew ☐ Vape ☐Other_____________________________

Alcohol Use: ☐No ☐Yes ☐Sober_______ If YES how often: ☐ Daily ☐Weekly ☐Social ☐Occasionally
Choice of alcohol: ☐Beer ☐Hard Liquor ☐Wine

Caffeine Use: ☐No ☐Yes Type: ☐Coffee ☐Tea ☐Soda ☐Energy Drink
If so how often: 1 2 3 4 5 _______________per day

Recreational Drug Use: ☐NO ☐Yes Type:______________________________ Frequency: ________________________

MEDICATIONS

Please list **ALL** medication you currently have a prescription for

Medication	Dose	Frequency	Prescribing Doctor

Please list **ALL** Over the Counter Medications, Vitamins, and Supplements

Medication	Dose	Frequency	Prescribing Doctor

Authorization for Disclosure of Confidential Information

Patient Name: ______________________________

Date of Birth: ______________ **SSN:** ______________

Address: ______________________________

I hereby authorize Nasser Cardiology, P.A. to:

- **Release to**
- **Receive from**

Name of Person or Facility: ______________________________

Street Address: ______________________________

City, State, Zip ______________________ **Phone:** ______________

Fax: ______________

- **History and Physical**
- **Lab Results**
- **Cath Reports**
- **Radiology Reports**
- **Nuclear Stress Test**
- **Echo Doppler**
- **EKG**
- **ALL RECORDS**

Signature: ______________________ **Date:** ______________

If you are not the patient, please specify your relationship to the patient:______________

CONTACT CONSENT FORM

________ I consent to Nasser Cardiology, P.A. releasing medical information to any specialist that I am referred to and/or that I have listed below as current providers for continuation of care.

Primary Care Physician (PCP):________________________________ Phone: ____
Referring Provider: __________________________________ Specialty: ___________________ Phone: _____________________
Medical Provider: ___________________________________ Specialty: ___________________ Phone: _____________________
Medical Provider: ___________________________________ Specialty: ___________________ Phone: _____________________

________ I consent to Nasser Cardiology, P.A. mailing bills to the listed Address.
________ I consent to Nasser Cardiology, P.A. Leaving Voicemails on the listed phone numbers.
________ I consent to Nasser Cardiology, P.A. Sending Text Messages to the listed Phone Numbers.(data rates may apply)

_______Nasser Cardiology, P.A. **MAY NOT** discuss my healthcare and **MAY NOT** discuss and/or make financial Arrangements with anyone, Other than Myself, except as permitted by HIPAA and other applicable laws.

_______Nasser Cardiology, P.A. **MAY** discuss my healthcare and **MAY** discuss and/or make financial arrangements with only the following individuals listed below:

Name:_____________________________________ Relationship:________________ Phone:______________________________
Name:_____________________________________ Relationship:________________ Phone:______________________________
Name:_____________________________________ Relationship:________________ Phone:______________________________
Name:_____________________________________ Relationship:________________ Phone:______________________________

I understand that if I would like to authorize Nasser Cardiology, P.A. to disclose my healthcare and/or financial arrangements with anyone other than the individuals listed above, I will need to execute an authorization that meets the requirements of the HIPAA Privacy Standards.

Printed Name:_____________________________________ **Signature**:__________________________ **Date**:________________
If you are not the patient, please specify your relationship to the patient:__________________________________

Please provide a date upon which this Authorization will expire. **Please mark only one selection**.
☐ No Expiration
☐Date of Expiration _______/_______/_______

CONSENT FOR TREATMENT

I voluntarily give my permission to the health care providers of Nasser Cardiology, P.A. and such Assistants as they may deem necessary to provide medical care services to me. I understand that by signing below, I am authorizing them to treat me as long as I seek care Nasser Cardiology, P.A. providers, or until I withdraw my consent.

Signature: ____ **Date:** ______________________________
If you are not the patient, please specify your relationship to the patient:______________________________

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability Act of 1996 (HIPAA)/ I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare Providers involved in my treatment);
- Obtaining payment from third party payers (ex my insurance company);
- The day to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of you Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I May contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing at any time.
However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature: ____ **Date:** ______________________________
If you are not the patient, please specify your relationship to the patient:______________________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I____, hereby acknowledge receipt of Nasser Cardiology, P.A., Notice of privacy practices. The Notice of Privacy provides detailed information about how Nasser Cardiology, P.A., may use and disclose my confidential information.

I understand that Nasser Cardiology, P.A., reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

Signature: ____ **Date:** _____________________________________
If you are not the patient, please specify your relationship to the patient:___________________________________

INSURANCE BENEFIT INFORMATION AGREEMENT & WAIVER

This information is being provided to help you better understand the process of receiving benefits. We are providing an estimate of your benefits, not an exact quote of what you will owe.

- **We can only ESTIMATE your benefits, as your insurance company applies a disclaimer when quoting benefits "actual benefits will not be considered until a claim is filed."**
- **We share information we obtain from your insurance company with you and explain these to the best of our ability.**
- **If you still do not understand how your benefits are administered, it is YOUR responsibility to contact your insurance directly.**

Please initial below that you have read and understand this policy.

________________ When making an appointment, it is your responsibility to confirm with your insurance company that Dr. George Nasser is currently under contract with your plan. If your plan requires a referral and you or your primary care provider do not provide one by the scheduled appointment time, please be prepared to pay for your visit in full or reschedule.

________________ All patient financial responsibility is due at the time services are rendered. Any balances determined by your insurance company will be due at each visit. Please call our office prior to each visit if you need to know in advance how much you will owe.

________________Any balances accrued after the insurance has responded to any claims are required to be paid 30 days after receiving a statement. If you have a past due balance at the time of service for an appointment or testing, you will be responsible for the balance during your visit.

________________ I understand that Nasser Cardiology, P.A. does not accept Medicaid as primary OR secondary insurance coverage. I further understand that if I schedule an appointment and do not disclose that I am active with either of these plans OR I apply and receive Medicaid/Amerigroup benefits while under the care of Nasser Cardiology, P.A., I HEREBY AGREE TO PAY for any and all services I receive.

I have read, understand and have had an opportunity to ask questions regarding the information on this page and have a received a copy for my records.

PLEASE READ THIS ENTIRE FORM PRIOR TO SIGNING OR INITIALING

Signature: ____ **Date:** ____________________________

If you are not the patient, please specify your relationship to the patient:________________________________

OFFICE POLICIES

Welcome and thank you for choosing Nasser Cardiology, P.A. for your health care needs. We look forward to serving you and strive to provide you with the best quality of care. Please carefully review the following valuable information as it is intended to serve as your guide to a smooth and productive visit.

LATE ARRIVALS: We do our best to keep the schedule. When a patient arrives late it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you may be rescheduled so that other patients are not inconvenienced.

CHECK IN: Your time is very important to you and us. The first step in keeping your appointment on time is being prepared. This includes filling out all the required paperwork prior to your first appointment. It is extremely important that you provide each piece of information that is requested on both the Patient Information and Medical History Forms. This will avoid delays in creating your chart and account at your visit. Please arrive at least 15-20 minutes prior to your scheduled time so that all the paperwork may be completed PRIOR to seeing the physician. Although we verify your insurance benefits before your initial appointment, you must present your current insurance card along with a valid picture ID in order to verify your identity. This will ensure that all information is entered accurately and will prevent errors in filing claims. Without the insurance card, we will be unable to file with your insurance and you will be responsible for the charges. On EACH follow-up visit you will be asked to verify demographics and insurance information so that our records remain up to date.

RETURN CHECK FEE: There will be a return check fee of $35.00 posted to your account for all checks returned due to non-sufficient funds or closed accounts**.**

MEDICATION HISTORY: You are required to bring an UPDATED medication list EVERY visit, in which we will go over with you during the visit to ensure our records remain up to date.

NO SHOWS AND LATE CANCELLATIONS: We require a 24 hour advance notice if you must cancel your appointment. For your convenience, we offer appointment reminder calls 24-48 hours prior to your appointment which will allow you to cancel or reschedule at that time. If you NO-SHOW and appointment you may be subject to a $25.00 fee.

Signature: ____ **Date: ____________________________________**
If you are not the patient, please specify your relationship to the patient:___________________________________