Bay Area Cardiology Associates, P.A.
Consultative, Diagnostic & Interventional Cardiology

Thank you for choosing Bay Area Cardiology Associates, P.A. Enclosed, you will find ***patient registration forms***. Please fill out these forms and bring them with you at the time of your office appointment date: ________________ time: __________ at the location below:

❐ Brandon Office 635 Eichenfeld Drive Brandon, FL 33511 *(813) 684-6000*	❐ Sun City Office 3920 Galen Court Sun City Ctr., FL 33573 *(813) 634-7200*	❐ Tampa Office 10740 Palm River Road #370 Tampa, FL 33619 *(813) 684-6000*	❐ Riverview Office 13029 Summerfield Square Dr Riverview, FL 33578 *(813) 443-0880*

LOCAL PHARMACY NAME: ____

PHARMACY ADDRESS: ____

PHARMACY TELEPHONE: ____

MAIL ORDER PHARMACY NAME: ____

Please bring the following with you:

(1) The patient's insurance or Medicaid card
(2) Authorization or referral if required
(3) All current medications (bottles)

ATTENTION: ***Bay Area Cardiology provides you with the highest quality care. We therefore ask that you bring all related HOSPITAL RECORDS and/or MEDICAL RECORDS i.e., recent LABS, PROCEDURES, SURGERIES or TESTING since your last office visit.***

If you are new to our practice, PLEASE BRING ALL RECORDS PERTAINING to your CARDIAC HISTORY as your appointment may need to be rescheduled without these records.

Please arrive 15 minutes prior to appointment

Thank you for allowing us to assist in your care.

Bay Area Cardiology Associates, P.A.

Main/Billing Office: 635 Eichenfeld Drive • Brandon, FL 33511 • Office: 813-684-6000 • Fax: 813-654-9032
3920 Galen Court • Sun City Center, FL 33573 • Office: 813-634-7200
10740 Palm River Road • #370 • Tampa, FL 33619 • Office: 813-684-6000
13029 Summerfield Square Drive • Riverview, FL 33578 • Office: 813-443-0880

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Adm. FrontOffice 05/2017

PATIENT INFORMATION SHEET

Last Name: ______________________ First Name: ______________________ MI ________

Primary Address: ____ Apt. #________
(Florida address required, if out-of-state, fill in secondary)

Secondary Address: ______________________ Alternate Phone: ______________________

City: ______________________ State: ______________ Zip: ______________

Home Phone: ______________________ **Work Phone:** ______________________

E-Mail: ______________________ **REFERRAL SOURCE:** ☐ AD/NEWSPAPER ☐ FRIEND ☐ PCP ☐ HOSP ________ ☐ INTERNET ☐ OTHER: ____________

Date of Birth: ______________ **Marital Status:** ________ **Social Security:** ______________________

Sex: ______________ **Race/Ethnicity (Optional):** ______________________

Employer: ______________________

Spouse's Name: ______________________ **Spouse's Work:** ______________________

Spouse's Employer: ____

Number: ______________________

Emergency Contact: ______________________ **Relationship:** ______________________

Primary Insurance: ______________________ Secondary Ins: ______________________
(Primary Insurance card @ time of office visit to be copied) *(Present insurance card @ time of office visit to be copied)*

Name of Insured: ______________________ Relationship: ______________________

Date of Birth: ______________________ Social Security: # ______________________

Primary Care Physician: ____
Please have insurance card(s) ready to be copied upon completion of your information sheet.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. INSURANCE AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. If this account should be referred to a collection agency, (I will be responsible for any balances placed with collections). I have read and understand the office policy and procedure.

Driver's License #: ______________________ State Licensed: ______________________
Patient Signature: ______________________ Date: ______________________

Adm. Ptinform 05/2017

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PATIENT MEDICAL HISTORY

DATE____________________ Date of Birth__________________________________

PATIENT NAME:____ AGE:__________________

REFERRED DOCTOR:____

CHIEF COMPLAINT (reason for visit): ______________________________________

____

If you are here for a test (stress test, echocardiogram, holter monitor, etc.), do you know why it was ordered? ____

PAST MEDICAL HISTORY – 1:

Coronary artery disease IF YES Describe: ______________________________

Heart attack (myocardial infarction) IF YES Describe: ______________________________

Heart valve disease

- Mitral Valve Disorder IF YES Describe: ______________________________
- Aortic Valve Disorder IF YES Describe: ______________________________
- Tricuspid Valve Disorder IF YES Describe: ______________________________
- Pulmonary Valve Disorder IF YES Describe: ______________________________
- Murmur IF YES Describe: ______________________________
- Other heart valve disorders IF YES Describe: ______________________________

Congestive heart failure IF YES Describe: ______________________________

Cardiomyopathy

- Dilated Cardiomyopathy-(Enlarged Weak Heart) IF YES Describe: ______________________________
- Hypertrophic Cardiomyopathy-(Thick Heart) IF YES Describe: ______________________________
- Restrictive Cardiomyopathy IF YES Describe: ______________________________
- Other Cardiomyopathy IF YES Describe: ______________________________

Irregular heart beats

- Atrial Fibrillation (AF) IF YES Describe: ______________________________
- Atrial Flutter (AFL) IF YES Describe: ______________________________

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- Supraventricular tachycardia (SVT) IF YES Describe: ____________________
- Ventricular tachycardia (VT) IF YES Describe: ____________________
- Sick Sinus Syndrome (SSS) IF YES Describe: ____________________
- Wolff-Parkinson White Syndrome (WPW) IF YES Describe: ____________________
- A-V Block IF YES Describe: ____________________
- Sinus Tachycardia IF YES Describe: ____________________
- Sinus Bradycardia IF YES Describe: ____________________
- Right Bundle Branch Block IF YES Describe: ____________________
- Left Bundle Branch Block IF YES Describe: ____________________
- Other IF YES Describe: ____________________

Vascular disease

- Peripheral Artery Disease (PAD) IF YES Describe: ____________________
- Carotid Artery Stenosis IF YES Describe: ____________________
- Abdominal Aortic Aneurysm (AAA) IF YES Describe: ____________________
- Thoracic Aortic Aneurysm (TAA) IF YES Describe: ____________________
- Varicose vein(s) IF YES Describe: ____________________
- Venous Insufficiency IF YES Describe: ____________________
- Deep Vein Thrombosis (DVT) IF YES Describe: ____________________
- Pulmonary Embolism (PE) IF YES Describe: ____________________
- Other IF YES Describe: ____________________

Pulmonary hypertension IF YES Describe: ____________________

Congenital Heart Disease IF YES Describe: ____________________

- Atrial Septal Defect (ASD) IF YES Describe: ____________________
- Patent Foramen Ovale (PFO) IF YES Describe: ____________________
- Ventricular Septal Defect (VSD) IF YES Describe: ____________________
- Other Congenital Heart Disorders IF YES Describe: ____________________

Syncope (Fainting) IF YES Describe: ____________________

Any Other Cardiovascular History IF YES Describe: ____________________

PAST MEDICAL HISTORY- 2:

Hypertension (high blood pressure) IF YES Describe: ____________________
Hypotension (low blood pressure) IF YES Describe: ____________________

Hyperlipidemia IF YES Describe: ____________________
High Cholesterol IF YES Describe: ____________________
High Triglycerides IF YES Describe: ____________________

Diabetes Type 1 IF YES Describe: ____________________

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Diabetes Type 2	IF YES Describe: ____________
Diabetic Retinopathy	IF YES Describe: ____________
Diabetic Neuropathy	IF YES Describe: ____________
Diabetic Nephropathy	IF YES Describe: ____________

GI Disorder

• Peptic Ulcer	IF YES Describe: ____________
• Reflux (GERD)	IF YES Describe: ____________
• Hiatal Hernia	IF YES Describe: ____________
• Hepatitis A	IF YES Describe: ____________
• Hepatitis B	IF YES Describe: ____________
• Hepatitis C	IF YES Describe: ____________
• Cirrhosis	IF YES Describe: ____________
• Crohn's Disease	IF YES Describe: ____________
• Irritable Bowel Syndrome (IBS)	IF YES Describe: ____________
• Ulcerative colitis	IF YES Describe: ____________
• Other	IF YES Describe: ____________

Lung disease

• Asthma	IF YES Describe: ____________
• COPD (Chronic obstructive pulmonary disease)	IF YES Describe: ____________
• Sleep apnea	IF YES Describe: ____________
• Pulmonary nodules	IF YES Describe: ____________
• Other	IF YES Describe: ____________

Kidney disease

• Renal Insufficiency	IF YES Describe: ____________
• Renal Failure	IF YES Describe: ____________
• Urinary Calculus (Renal Stones)	IF YES Describe: ____________
• Other	IF YES Describe: ____________

Arthritis

• Osteoarthritis	IF YES Describe: ____________
• Rheumatoid arthritis	IF YES Describe: ____________
• Scleroderma	IF YES Describe: ____________
• Systemic Lupus Erythematosus	IF YES Describe: ____________
• Psoriasis	IF YES Describe: ____________
• Backache	IF YES Describe: ____________
• Other	IF YES Describe: ____________

Blood Disorders

- Anemia — IF YES Describe: ______________________
- Thrombocytopenia — IF YES Describe: ______________________
- Bleeding disorder — IF YES Describe: ______________________
- Other — IF YES Describe: ______________________

Thyroid Disease

- Hyperthyroidism — IF YES Describe: ______________________
- Hypothyroidism — IF YES Describe: ______________________
- Other — IF YES Describe: ______________________

Neurology

- Stroke or cerebrovascular accident (CVA) — IF YES Describe: ______________________
- Mini stroke or transient ischemia attack (TIA) — IF YES Describe: ______________________
- Depression / anxiety / dementia — IF YES Describe: ______________________
- Seizure — IF YES Describe: ______________________
- Neuropathy — IF YES Describe: ______________________
- Other — IF YES Describe: ______________________

Cancer

- Breast — IF YES Describe: ______________________
- Lung — IF YES Describe: ______________________
- Rectal — IF YES Describe: ______________________
- Colon Cancer — IF YES Describe: ______________________
- Lymphoma — IF YES Describe: ______________________
- Other — IF YES Describe: ______________________

Edema — IF YES Describe: ______________________

Prostate Disease (MALE ONLY) — IF YES Describe: ______________________

Erectile Dysfunction (MALE ONLY) — IF YES Describe: ______________________

PAST SURGICAL HISTORY-1:

Pacemaker — IF YES Describe: ______________________
Defibrillation (ICD) — IF YES Describe: ______________________
Bypass surgery — IF YES Describe: ______________________
Heart valve surgery — IF YES Describe: ______________________

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Vascular Surgery

- Leg bypass Left Right — IF YES Describe: ______
- Abdominal aortic aneurysm — IF YES Describe: ______
- Carotid surgery (neck) — IF YES Describe: ______
- Varicose vein — IF YES Describe: ______
- Other — IF YES Describe: ______

PAST SURGICAL HISTORY-2:

Appendectomy (Appendix) — IF YES Describe: ______
Cholecystectomy (Gallbladder) — IF YES Describe: ______
Hysterectomy (Uterus) — IF YES Describe: ______
Thyroid Surgery — IF YES Describe: ______
Hip Surgery — IF YES Describe: ______
Knee Surgery — IF YES Describe: ______
Shoulder Surgery — IF YES Describe: ______
Inguinal Hernia Repair — IF YES Describe: ______
Prostate Surgery — IF YES Describe: ______
Laminectomy — IF YES Describe: ______
Cataracts — IF YES Describe: ______
Limb Amputation — IF YES Describe: ______
Other — IF YES Describe: ______

MEDICATIONS:

Currently taking medications? **(If YES, please LIST ALL)**

❐ YES ❐ NO

1. Aspirin 81 mg / 325 mg
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______