

.Statesboro Cardiology, P.A.

5 Grady Johnson Road* Statesboro, GA 30458 * (912) 489-6246 * (912) 489-6346

Patient Registration Form

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip Code _____

Phone: Home _____ Cell _____ Work _____

What number would you prefer to be contacted at? _____

E-mail address: _____

SSN: _____ DOB: _____

Please Circle:

Gender: Female / Male **Race:** Declined / American Indian / Asian / Black or African American / White / Other

Ethnic Group: Declined / Hispanic / Non-Hispanic **Marital Status:** Single / Divorced / Married / Widowed

Emergency contact: _____ **Relationship:** _____ **Phone** _____

Responsible Party: _____ **Relationship:** _____ **Phone** _____

Address: _____ **City** _____ **State:** _____ **Zip:** _____

SSN: _____ **DOB:** _____

Primary Care Physician: _____

Preferred LAB: _____ **QUEST** _____ **LABCORP** **Pharmacy:** _____

Disclosure of Protected Health Information

By law, medical information is confidential unless written authorization is given. Therefore, upon signing this form, I _____ am authorizing Statesboro Cardiology, P.A. to give medical information to (name and relation):

OR- Do not disclose medical information to anyone other than myself. _____ (Initial)

Acknowledgement of Privacy Practices

By signing this form I acknowledge that I have been provided with the above practice's **Notice of Privacy Practices** to review, and informed that I may keep a copy for reference or obtain a copy upon request.

Release and Assignment

I authorize the release of any medical or other information necessary to process my insurance claims.

I authorize and request payment of medical benefits directly to my physician.

I agree that this authorization will cover all medical services rendered until such authorization is revoked by me in writing.

I agree that a photocopy of this form may be used in lieu of the original.

I agree to pay all statements not covered by the insurance for the services rendered by my physician.

Patient or authorized representative signature

Date

Statesboro Cardiology, P.A.

Stanley J. Shin, MD, FACC, FACP
David R. Nabert, MD, FACC, FHRS
Abraham Lin, MD, FACC, FSCAI, RPVI
Julio E Schwarz, MD, FACC
Jenny R. Janney, PA
Stephanie Pinard, NP
Sara Lusted, NP

5 Grady Johnson Road
Statesboro, GA 30458
Phone:(912) 489-6246
Fax: (912) 489-6346

Medical Records Request Form

Please fax the following requested records to 912-489-6346 Requested By: _____

TO: _____

FAX: _____ PHONE: _____

Patients Name: _____

Patients DOB: _____

Patients SSN (last 4): _____

TIME FRAME REQUESTED: _____

- Discharge Summary
- History and Physical
- Operative Report _____
- Nuclear Stress Test
- Chest X-Ray
- Echo Report
- EKG
- Holter/Event Report
- Lab Work
- Cath Report
- Other: _____

I authorize you to release my medical information to Statesboro Cardiology, PA concerning my illness and/or treatment. I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, psychiatric disorders or HIV testing. This request expires in 6 months.

Patients Signature

Patients DOB

Date

Statesboro Cardiology, P.A.

Dr. Stanley J. Shin, MD, FACC, FACP
Dr. David R. Nabert, MD, FACC, FHRS
Dr. Abraham K. Lin, M
Dr. Julio E Schwarz, MD
Jenny R. Janney, PA
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HIPAA Notice of Privacy Practices

Acknowledgment and Consent

By signing below, I acknowledge that I have been provided a copy of this Notice of privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by the providers listed in the heading of this notice, and how I may obtain access to, and control of this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information from my provider. Finally, by signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the practice, its staff, and its business associates.

Printed Name of Patient

Signature of Patient or Patients Representative

Printed Name of Patient or Patients Representative

Date

Relationship of Patients Representative

Patient History Form

PLEASE PRINT

Name _____ Date of Birth _____ Date _____

Please Check: Male _____ Female _____
 Married _____ Separated _____ Divorced _____ Widowed _____ Single _____

Education: Elementary _____ High School _____ College, Technical School _____

Occupation: _____ Retired _____

Physical Requirements of Occupation: _____

Daily Exercise: _____

Recreational Activities and Hobbies: _____

Family History

	Living	Age or Age at Death	Present health or cause of death
Father	Yes No _____	_____	_____
Mother	Yes No _____	_____	_____
Spouse	Yes No _____	_____	_____

Present Years Marriage _____ Previous Marriage Years and Duration _____

Brother(s) # Living _____ Health Status: _____

Deceased _____ Cause of death: _____

Sister(s) # Living _____ Health Status: _____

Deceased _____ Cause of death: _____

Children # Living _____ Health Status: _____

Deceased _____ Cause of death: _____

Please check illness or conditions YOU have had....

High Blood Pressure	Diabetes	Family History of Heart Disease or Stroke	Leg Pain when Walking
Obesity	No Exercise	High Cholesterol	Glaucoma
Venereal Disease	Cancer	Bleeding Tendency	Kidney Disorder
Nervous Disorder	Pneumonia	Rheumatic Fever	Vein Trouble
			Jaundice
			Arthritis
			Heart Trouble
			Stroke
			Tuberculosis
			Asthma

Personal Habits: (Please Check)

Yes No Do you use tobacco products? If yes, Cigarettes Pipe Cigars Smokeless Tobacco
 Yes No Do you have a history of tobacco use?
 Yes No Do you drink more than 6 cups of coffee per day?
 Yes No Do you drink alcohol? If yes, how much? _____

Other Information

Please list all medications: _____

Have you had serious injuries, broken bones, etc.? _____

If so, please list: _____

Have you had any allergies or sensitivity to medications or other substances? _____

If so, please describe: _____

Write the names and years of any operations that you have had: _____

Tubal Ligation or Hysterectomy: _____

Recent Hospitalization non-surgical: When: _____ Where: _____