.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
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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

Statesboro Cardiology, P.A. 5 Grady Johnson Rd, Statesboro, GA 30458

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 • Heart Trouble • Stroke

• Venereal Disease • Cancer • Bleeding Tendency • Kidney Disorder • Tuberculosis • Asthma

• Nervous Disorder • Pneumonia • Rheumatic Fever • Vein Trouble • Jaundice • Arthritis

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:_____