**New Patient Personal Data Form.**

Patient's Name___________________________

Date of Birth _____/____/______

Home Phone # (____) ______ - ________

Cell/Work Phone # (____) ______-______

Social Security #________________________

Home Address : _____________________________________________

___________________________________________________________

Marital Status: S M W D (circle one)

Spouse Name ______________________

Spouse Date of Birth _____/_____/_______

Spouse Social Security # ___________________________

Email Address: (optional) ____________ @ _________________

May we contact you by Phone to remind you of appointments? ________

May we leave appointment messages at your home phone number? _______

May we leave Phone messages regarding normal labs and testing? ________

May we contact you by e-mail? __________________

May we contact you by regular mail? _____________

May we discuss your appointments, labs results, hospitalization, medical condition and / or account balance with your spouse? _________________

Emergency Contact's Name: ________________________

Emergency contact's Phone Number: _____________________

Emergency Contact Address: ______________________________________

______________________________________________________________

May we discuss your appointments, labs results, hospitalization, medical conditions, and / or account balance with your emergency contact? _______

Do you have an Advance Directive or Living Will? _________

If so, we request that you provide our office with a current copy and additional copies as you update and / or modify these documents.

Do you have a PCP or family doctor? _____________

Name of your PCP or family doctor: ___________________________

Phone # of your PCP or family doctor: (____) ______ - _________

Do you authorize us to share medical information, labs results, or hospitalization with your PCP or family doctor? ______________

Patient Signature: _______________________

Date: ____/_____/_______

**Primary Insurance Information:**

Primary Insurance Name: ___________________________________

Policy Holder's Name: ___________________________________

Policy Number: ____________________________________________

Group Number: ____________________________________________

Address for filing claims: ____________________________________

__________________________________________________________

**Secondary Insurance Information:**

Secondary insurance Name: ______________________________
Policy Holder's Name: _________________________________
Policy Number: ______________________________________
Group Number: ______________________________________
Address for filing claims: _______________________________
____________________________________________________

**Patient Account Responsibility**:
Person responsible for this patient account payments:
Name: ___________________________
Home Phone #: ______________________
Address of person responsible for Account: ____________________
_____________________________________________________
Date of Birth: ____/_____/______
Social Security # ____________________



**Authorization for Payment / Insurance Assignment of Benefits.**

I hereby authorize my insurance carrier (s) to assign All Insurance / Benefits to Adel M. Eldin, M.D. for all services and procedures rendered. I understand that I am financially responsible for all charges whether they are

paid by insurance or not. I, the undersigned authorize the released of medical records or health information required to process insurance claims. I understand that payments of all charges are my primary responsibility. If my insurance requires prior authorization or a referral for an office visit, test or procedure, I understand that is my responsibility to obtain such authorization or referral prior to scheduling such an appointment. I understand that without proper authorization or referral, I will not be able to see the physician. **I understand that co-payments are expected on the date of service, unless otherwise pre-arranged with the billing department representative.**

Printed your Name: ____________________________________

Signature: ___________________________________________

Date: _______/______/_______

**Patient Account Statements:**

Patients account statements are sent monthly to patients that have any balance. To ensure that we are sending your statement to the correct address, please notify our office of any changes in your address. Patients are asked to pay their bill promptly. If you dispute any bill, please contact us so that we might address your concerns. Brooksville Cardiology is willing to make arrangement with patient whose are subject to financial hardship. Please talk to us that we can reach an arrangement regarding payments. We will do our best to work out an arrangement with you that is fair for both you and Brooksville Cardiology. Patient who refuse to make payments on their accounts are required by Brooksville Cardiology may be subject to collection proceedings. Once collection proceeding begins the patient will be also subject to a $75.00 fee in addition patient may be subject to attorney's fees, Court and interest.
Your Initials: ___________



**Insufficient Funds / returned Checks.**

Patients who submits checks that are returned for Insufficient Funds will have their account charged $35.00
Your Initials: __________________

## Brooksville Cardiology Office Policy.

It is the policy of Brooksville Cardiology to treat our patient as we would are own family. We are here because our patient's and their continuo desire our services. We encourage our patients to give us their comments and suggestions. If there is anything that we can do to make their visits more pleasant of comfortable, please let us know. We understand that some patients get anxious about their appointments or test results we will do our best to be sensitive to your concerns and apprehension. In return we hope that you will treat our staff as you would like to be treated. Please keep in mind that in occasion the appointment of another patient may last longer than expected. Our promise is to treat all our Patients with the same careful attention and sensitivity. Your information is always kept confidential.

**Patient Medical information.**

Have you recently had any of the following complaint?

_____ Chest Pain
_____ Leg Pain
_____ Fainting
_____ Almost Fainting
_____ Weakness
_____ Fever
_____ Dizziness
_____ Pain in Neck
_____ Pain in Back
_____ Abdominal Pain
_____ Vomiting
_____ Joint Pain
_____ Swelling in your legs or arms
_____ Difficulty Controlling Bleeding
_____ Feeling fast Heartbeat / Palpitations
_____ Gained more than 10 lbs in two months
_____ Loss more than 10 lbs in two months

______ Shortness of Breath
______ Nose-bleeding
______ Constipation
______ Diarrhea
______ Blood in Urine
______ Blood in Stool
______ Headaches
______ Pain in Jaw
______ Blurry Vision
______ Unusual Bruising
______ Muscle Cramps
______ Excessive Sweating
______ Irregular heart beat



Have you ever been prescribed Antibiotics? ___________________
Have you ever been prescribed Pain Medication? _______________
Have you ever eating Shell Fish? ____________
Have you ever under-went testing that required IVP Dyed? ________
Are you Allergic to Iodine? _________

Have you ever been Diagnose with any of the following Conditions.

_____ Arthritis
_____ Anemia
_____ Bleeding Disorder
_____ Diabetes
_____ High Cholesterol
_____ Heart Disease
_____ Gastritis
_____ HIV
_____ Fibromyalgia
_____ Peripheral Vascular Disease
_____ Stroke or TIA
_____ Seizure Disorder

______ Coronary Artery Disease
______ Cancer
______ Congenital Heart Disease
______ Heart Murmur
______ High Blood Pressure
______ Hepatitis
______ Kidney Disease
______ Migraine
______ Lupus
______ Poor Circulation
______ Stomach Ulcers
______ Lyme Disease

**Please List all Surgeries or Hospitalization.**

| **Date:** | **Procedure:** | **Reason for Hospitalization;** |
|---|---|---|
| _______ | _____________ | ________________________ |
| _______ | _____________ | ________________________ |
| _______ | _____________ | ________________________ |
| _______ | _____________ | ________________________ |
| _______ | _____________ | ________________________ |
| _______ | _____________ | ________________________ |
| _______ | _____________ | ________________________ |



**Has anyone in your Family been Diagnose with any of the following.**

| Mother | Father | Brother | Sister | |
|---|---|---|---|---|
| ______ | ______ | ______ | ______ | Heart Disease |

_______ _______ _______ _______ Heart Attacks
_______ _______ _______ _______ Stroke / TIA
_______ _______ _______ _______ High Blood Pressure
_______ _______ _______ _______ Diabetes
_______ _______ _______ _______ Arthritis
_______ _______ _______ _______ Lung Disease
_______ _______ _______ _______ Kidney Disease
_______ _______ _______ _______ Thyroid Problems
_______ _______ _______ _______ Seizure Disorders
_______ _______ _______ _______ Cancer
_______ _______ _______ _______ High Cholesterol

**Please List all medication that you are currently taking:**

**Medication** **Dosage/ Strength** **Frequency**

_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________