CARDIOVASCULAR MEDICAL ASSOCIATES

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Patient Registration Form

Date *(Fecha)***:** _____

Name: _____ **SSN:** _____
Last (*Apellido),* **First** *(Nombre),* **Middle***(segundo nombre)*

Date of Birth *(Fecha De Nacimiento)***:** _____/_____/_____ **Marital Status** *(Estado Civil)***:** _____ **Sex:** _____

Address *(Dirreccion)***:** _____
Number Street City State Zip Code

Email Address *(Correo electronic)* _____

Home # *(Telefono)***:** _____ **Cell #:** _____

Do you reside in a nursing home? YES NO **Nursing Home:** _____ **Telephone #:** _____
Usted vive en un asilo *El nombre del asilo* *Telefono*

Primary Language: *(Idioma Primario* _____

Primary Care Physician (*Doctor Primario*)**:** _____ **PCP Tel #** (*Numero de primerio)* **:** _____

Emergency Contact :_____ **Emergency Contact Number:**_____
Nombre de contacto en caso de una emergencia *Numero de Contacto en caso de una emergencia*
Relationship (*Relacion con el paciente*): _____

Advanced Directive Information

Do you have an advanced directive/living will? _____ YES NO
Usted tiene una directive de cuidado de la salud. Usted le gustaría information sobre la Directiva Anticipado la atención de la salud?

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third-party payers., and conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been informed and may receive a copy of the *Notice of Privacy Practices* form containing the uses and disclosures of my health information upon request.

Authorization for the Release of private health information

I consent to allow the following person(s) to have access to my health information and are Authorized Personal Representatives:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Method of Communicating Personal Health Information *Please indicate which you prefer.*
☐ Home phone ☐ Cell phone ☐ Leave messages on answering machine/voicemail answering phone

_____ _____
Patient/Representative Signature Relationship to Patient
(Firma del Paciente/Representavo) (Relacion con el paciente)

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NAME*(Nombre)* _____ **DOB** *(Fecha de Nacimiento)*_____

Allergies*(Alergias)*_____

History of past Illness (Have you had?) *Enfermedades pasadas (Ha tenido)*			**When?** *(Cuando?)*
Congestive heart failure/insuficiencia cardíaca	**NO**	**YES**	_____
Heart attack/Infarto de Corazón	**NO**	**YES**	_____
Heart disease/enfermedad del Corazón	**NO**	**YES**	_____
High Blood Pressure/Hipertensión	**NO**	**YES**	_____
High Cholesterol/ Colesterol alto	**NO**	**YES**	_____
Diabetes	**NO**	**YES**	_____
Strokes/Embolia	**NO**	**YES**	_____
Rheumatic Fever/Fiebre Reumática	**NO**	**YES**	_____
Anemia/Anemia	**NO**	**YES**	_____
Cancer	**NO**	**YES**	_____
Psychiatric Illness/Problemas Psychiátricos	**NO**	**YES**	_____
Muscles and Bones/Músculos o Huesos	**NO**	**YES**	_____
Problems with Liver/Problemas con Hígado	**NO**	**YES**	_____
Problems with Kidneys/Problemas con Riñones	**NO**	**YES**	_____
Asthmas/Asma	**NO**	**YES**	_____
Peptic Ulcer/Ulceras	**NO**	**YES**	_____
Serious Disease/Enfermadades Graves	**NO**	**YES**	_____
Sleeep Apnea	**NO**	**YES**	_____

Ever *Hospitalized* *(Ha sido Hospitalizado?)*
Explain/Explique_____

Ever had Surgery? ***(****Ha Tenido Cirugías?)*
Explain/Explique_____

Social History (Historia Social)	**Never/Nunca**	**Yes/Si**	**How much/Cuanto**
Alcoholic Beverages (Bebidas alcoholicas)			
Cigarettes (Tabacco o Cigarillos)			
Excercise (Ejercicio)			
Recreational drugs (Consume drogas)			

Have you ever had / Ha tenido -			**When / Cuando ?**
Stress test (examen de stress)	**NO**	**YES**	_____
Echocardiogram (ultrasonido del corazón)	**NO**	**YES**	_____
Cardiac Catherization (caterización cardíaca)	**NO**	**YES**	_____
Coronary Angioplasty (stent / angioplastía coronaria)	**NO**	**YES**	_____
Coronary Bypass Surgery (cirugía coronaria)	**NO**	**YES**	_____
Valve Surgery (cirugía de la válvula)	**NO**	**YES**	_____
Electrophysiology Study (EPS)	**NO**	**YES**	_____
Pacemaker or Difibrillator (Marcapaso)	**NO**	**YES**	_____

Family History/Historia Familia **Has anyone in your family ever had? /Alguien de su familia ha tenido?**

Heart Trouble (Enfermedad del Corazón)	**NO**	**YES**	_____
Stroke (Embolio)	**NO**	**YES**	_____
Diabetes	**NO**	**YES**	_____
Hypertension	**NO**	**YES**	_____