Conway Physicians Group
Waccamaw Cardiology

Andrew J. Gresko, MD, FACC | **Keith Wyche, MD, FACC** | **Michael A. Rosenblum, MD, FACC**

Acct. #________

Patient History Form

Patient Name:________________________ Referring MD: ________________

Date of Visit: ________________ Age: ______ Male ☐ Female ☐

Medication Allergies:________________________________

____

Are you allergic to seafood, shellfish, iodine or IVP dye? ________________

Medications: (***Please bring your medication bottle(s) to your office visit.***)

Do you take an aspirin daily? 81 mg or 325 mg? ________________

Do you have Nitroglycerine tablets or spray? ________________

Please list all medications:

Drug	Dosage	Times taken daily	Drug	Dosage	Times taken daily

List Medical History:

Condition	Yes	No
Coronary Artery Disease	☐	☐
Congestive Heart Failure	☐	☐
Heart Valve Disease	☐	☐
Arrhythmia or an abnormal heart rhythm	☐	☐
High Cholesterol	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Kidney Disease	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Peripheral Vascular Disease	☐	☐
Thyroid Disease	☐	☐
Lung Disease	☐	☐

Social History:

Do you smoke? Yes ☐ No ☐

Date that you quit smoking ____________

How many years have you smoked? ____________

How many packs per day? ____________

Do you drink alcohol/beer? Yes ☐ No ☐

How much? ____________

Single ☐ Married ☐ Divorced ☐ Widowed ☐

# of Children________ Grandchildren ________

# of Great-Grandchildren____________

Where were you born?____________

What is your occupation?____________

If retired, what was your occupation prior to retirement?

____

When did you move to this area?____________

Please list previous surgeries and dates: ________________________

____

____

Family History:

Mother: Living ☐ Deceased ☐ Age:______ Illnesses: ________________
Heart Disease Yes ☐ No ☐

Father: Living ☐ Deceased ☐ Age:______ Illnesses: ________________
Heart Disease Yes ☐ No ☐

Brothers: Living ☐ Deceased ☐ Ages:______ Illnesses: ________________
Heart Disease Yes ☐ No ☐

Sisters: Living ☐ Deceased ☐ Ages:______ Illnesses: ________________
Heart Disease Yes ☐ No ☐

CPG Waccamaw Cardiology

Compound Authorization for Release of Information

Name of Patient ________________________________ Date of Birth ____________

CPG Waccamaw Cardiology is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Person Authorized to Receive Protected Health Information About You:
Check each person/entity that you approve to receive information.

☐ **Spouse** (provide name): ________________________________

Authorized to receive information regarding:

- O Financial Information
- O Medical Information

☐ **Parent** (provide name): ________________________________

Authorized to receive information regarding:

- O Financial Information
- O Medical Information

☐ **Employer** (provide name): ________________________________

Authorized to receive information regarding:

- O Appointment absentee information

☐ **School** (provide name): ________________________________

Authorized to receive information regarding:

- O Appointment absentee information

☐ **Referring Physician** (provide name): ________________________________

Authorized to receive information regarding:

- O Medical Information
- O Appointment Information

☐ **Other** (provide name): ________________________________

Authorized to receive information regarding:

- O Financial Information
- O Medical Information

I give authorization for the release of protected health information on voice mail.

☐ Yes ☐ No

Authorized to receive information regarding:

- O Results of tests that are normal (including but not limited to lab and x-rays)
- O Appointment Information
- O Prescription Refill Information
- O Other Information as follows:

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to CPG Waccamaw Cardiology. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

________________________________ Date ____________

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

____

CPG Waccamaw Cardiology

Patient Information

Patient name	DOB	Age	Gender – Circle one Male Female	Today's Date
Address	Home phone	Cell phone	e-mail	
City/State/Zip	SS#	Marital Status - Circle one S M D W		

Race	Religion	Highest Level Of Education	Ethnicity	Preferred Language

Emergency Contact	Relationship	Phone # (H) (C)

Patient Employment Information

Employer	Contact name	Work number
Address	City/State/Zip	

Guarantor Insurance Information

Primary Insurance	Employer	Secondary Insurance	Employer
Policy #	Group #	Policy #	Group #
Insured Name		Insured Name	
Address		Address	
City/State/Zip		City/State/Zip	
Insured DOB	Insured SS#	Insured DOB	Insured SS#

Guarantor Employment Information

Employer	Contact name	Work number
Address	City/State/Zip	

Additional Information

Parent/Guardian Name	Day Phone

Referral Information

How did you hear about us?

Consent for Healthcare and Release of Medical Information

I voluntarily consent to treatment at this facility by its physicians and staff. No guarantees have been made to me about the results of treatments or examination by staff at this practice. I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I have read this form and had the opportunity to ask questions.

Financial Responsibility and Assignment of Insurance Benefits

I authorize **CPG Waccamaw Cardiology** to bill my insurance company using the information I have provided to this office for payment to their **MEDICAL FACILITY**. I assign payment for the unpaid charges for certain physician services to **CPG Waccamaw Cardiology**. I understand I am responsible for any health insurance deductible and co-insurance payments. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any medical or any other information about me to be released to the Social Security Administration or its intermediaries or carriers and any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf. I authorize the medical facility to use the e-mail address given above for the purpose of communications related to financial responsibility and assignment of insurance benefits.

Signature of Patient or Authorized Person: ______________________ **Date:** __________

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. I am aware that the Notice may be changed at any time and that I may request a copy of the revised notice by contacting the Office Manager.

Signature of Patient or Authorized Person: ______________________ **Date:** __________

FOR STAFF USE ONLY

- ☐ Patient refused to sign
- ☐ Patient refused to sign after receiving the Notice. Explanation provided that signature only documents that the Notice was received.
- ☐ Unable to provide NPP due to an emergency situation and the patient was not able to sign
- ☐ Patient refused copy of NPP but understands a copy is available upon request.

Signature of: ______________________ **Date:** __________