

# NSC Cardiology - NEW PATIENT VISIT FORM

(Complete if you have not been seen in over 3 years or are coming to this office for the first time)

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

EMAIL \_\_\_\_\_ Referring Dr \_\_\_\_\_

Which physician are you seeing today?  Dr Singh/Taylor Mabe NP  Dr Reingold

Why are you here? Any specific questions for the doctor?

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## CARDIAC HISTORY:

Any recent heart tests? **If yes, please notify the staff to request copies of the reports**

Echo (cardiac ultrasound)  Stress test  Nuclear stress test  Heart Cath  
 others \_\_\_\_\_

Do you;

Have High blood pressure	yes	no	# of yrs	_____
Have High cholesterol	yes	no	# of yrs	_____
Have Diabetes	yes	no	# of yrs	_____
Smoke	yes	no	# of yrs	quit when? _____
Drink alcohol	yes	no	# of yrs	amt/week? _____
Exercise at least 3x/week	yes	no	what activity?	_____

Have previous heart attack	yes	no	when?	_____
Have Previous Stroke	yes	no	when?	_____
Have previous heart surgery	yes	no	when?	_____
Have previous vascular surgery	yes	no	when?	_____

Get chest pains/pressure	yes	no	describe	_____
Get dizzy or faint	yes	no	describe	_____
Get racing heart/skip beats	yes	no	describe	_____
Get shortness of breath	yes	no	describe	_____
Get leg swelling	yes	no	describe	_____
Have a heart murmur?	Yes	no	describe	_____

Current medication list (include herbs/supplements and doses)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current allergy list

_____	_____
_____	_____
_____	_____

Shellfish allergy      yes      no

IV dye allergy      yes      no

**PAST MEDICAL HISTORY:**

List all surgeries and year.

\_\_\_\_\_  
\_\_\_\_\_

List all other hospitalizations and year.

\_\_\_\_\_  
\_\_\_\_\_

Any other ongoing medical problems?

\_\_\_\_\_

**FAMILY HISTORY:**

Any family History of heart disease?

Who?

Relation.....

Condition.....

Relation.....

Condition.....

Relation.....

Condition.....

Mothers age\_\_\_\_\_

If deceased, cause of death\_\_\_\_\_

Fathers age\_\_\_\_\_

If deceased, cause of death\_\_\_\_\_

Siblings? Yes No

Any health Issues? \_\_\_\_\_

**PSYCHO-SOCIAL HISTORY:**

Where were you born?\_\_\_\_\_Your Ethnicity\_\_\_\_\_

Are you? Single married divorced widowed common law partner

Are you? employed unemployed disabled retired student stay at home

Where do or did you work?\_\_\_\_\_

Describe your current or past job\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have children? Yes No Ages\_\_\_\_\_

Are you? under any unusual stress? Yes No Please describe below?

\_\_\_\_\_  
\_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

# NSC CARDIOLOGY - REVIEW OF SYSTEMS

(to be filled out if not done in the past 3 months)

NAME \_\_\_\_\_ NO CHANGE SINCE LAST VISIT

PLEASE INDICATE BELOW ONLY IF ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

## General, constitutional

Poor general health lately ..... yes  
Recent weight loss ..... yes  
Fever/ chills ..... yes  
Fatigue ..... yes

## Eyes and vision

Eye disease or injury ..... yes  
Wear glasses or contact lenses ..... yes  
Blurred or double vision ..... yes  
Glaucoma ..... yes

## Ears, nose, throat

Hearing loss ..... yes  
Ringing in the ears ..... yes  
Sinus problems ..... yes  
Nose bleeds ..... yes  
Bleeding gums ..... yes  
Sore throat or voice change ..... yes

## Genitourinary

Frequent urination ..... yes  
Burning or painful urination ..... yes  
Blood in urine ..... yes  
Sexual difficulty/pain ..... yes  
Irregular periods (female) ..... yes  
Erectile dysfunction (male) ..... yes

## Respiratory

Frequent coughing ..... yes  
Spitting up blood ..... yes  
Shortness of breath ..... yes  
Asthma or wheezing ..... yes

## Gastrointestinal /Extremities

Loss of appetite ..... yes  
Constipation ..... yes  
Nausea or vomiting ..... yes  
Frequent diarrhea ..... yes  
Blood in stool ..... yes  
Leg cramps/pain ..... yes  
Restless legs ..... yes  
Leg ulcers/redness ..... yes

## Musculoskeletal

Joint pain ..... yes  
Joint stiffness or swelling ..... yes  
Weakness of muscles/joints ..... yes  
Muscle pain or cramps ..... yes  
Back pain ..... yes  
Difficulty in walking ..... yes

## Skin and breasts

Rash or itching ..... yes  
Change in skin color ..... yes  
Varicose veins ..... yes  
Breast pain ..... yes

## Neurological

Frequent or recurrent headaches ..... yes  
Lightheaded or dizzy ..... yes  
Convulsions or tingling sensations ..... yes  
Tremors ..... yes  
Strokes / TIA ..... yes  
Head injury ..... yes

## Psychiatric

Memory loss or confusion ..... yes  
Nervousness/ anxiety ..... yes  
Depression ..... yes  
Sleep problems ..... yes  
Snoring/apnea ..... yes

## Endocrine

Glandular or hormone problem ..... yes  
Thyroid disease ..... yes  
Diabetes ..... yes  
Excessive thirst or urination ..... yes  
Heat or cold intolerance ..... yes

## Hematologic/ Lymphatic

Slow to heal after cuts ..... yes  
Easily bruise or bleed ..... yes  
Anemia ..... yes  
Phlebitis ..... yes  
Transfusion ..... yes  
Swollen glands ..... yes

ANY OTHER PROBLEMS:

\_\_\_\_\_

Date: \_\_\_\_\_

Signature \_\_\_\_\_

# NSC Cardiology Inc – www.heartdrsingh.com

## PATIENT PROFILE

**IF UNCHANGED FROM INFO ALREADY ON FILE - JUST SIGN AT BOTTOM OF PAGE**

Which physician are you seeing today?       Dr Singh/Taylor Mabe NP       Dr Reingold

### PATIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Gender at birth       Male       Female

Date of Birth:mm/dd/yyyy \_\_\_\_\_

Social Security #: \_\_\_\_\_

Married  Single  Widowed  other

Spouse/Partner Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Physician Phone #: \_\_\_\_\_

### PATIENT EMPLOYMENT

Employed       Retired       Unemployed

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

### PHARMACY INFORMATION

Pharmacy Name: \_\_\_\_\_

Pharmacy #: \_\_\_\_\_

### GUARANTOR (Individual signing this form)

Same as Patient       Other

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

### GUARANTOR PHONE

Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_

### EMERGENCY CONTACT & PHONE #:

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### PRIMARY INSURANCE

**\*Secondary Insurance: Please Provide Information to Front Desk**

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Phone #: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Insurance Co Address: \_\_\_\_\_  
\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Policy Holder's SSN: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_

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I consent to have messages regarding test results and appointment reminders left on a voicemail: (Initial)

\_\_\_\_\_ Voicemail/Home #: \_\_\_\_\_

\_\_\_\_\_ Voicemail/Cell #: \_\_\_\_\_

\_\_\_\_\_ Voicemail/Business #: \_\_\_\_\_

I do not consent to have messages regarding my test results or appointment reminders on any voicemail: \_\_\_\_\_ (Initial)

1. I voluntarily give consent for my medical treatment or my child's medical treatment to NSC Cardiology Inc. **I fully understand that payment is required at the time of service and should my claims be filed to my insurance company, any unpaid balance is my responsibility.** When necessary, I further authorize the release of medical records to my insurance company. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician. **If you are seen by Dr Reingold please note that you will be billed by Georgia Integrative Cardiology, LLC.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**NSC Cardiology Inc – [www.heartdrsingh.com](http://www.heartdrsingh.com)**  
**Dr. Narendra Singh Dr Jason Reingold**

**PATIENT CONSENT FORM**

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.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

**Please list to whom we may release your medical records/information.**

Name/Relationship: \_\_\_\_\_  
\_\_\_\_\_

**Research:** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one medication to those who received another, for the same condition. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been reviewed through this approval process. We may disclose medical information about you to people conducting a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave NSC Cardiology Inc., NSC Research Inc. We will almost always ask for your specific permission if the researcher will have access to your name or other information that reveals who you are, or actively be involved in your care at NSC Cardiology Inc., NSC Research, Inc.

**ACKNOWLEDGEMENT FORM**

I have reviewed the **Notice of Privacy Practices** (available at [www.heartdrsingh.com](http://www.heartdrsingh.com) or ask for a copy) and have been presented an opportunity to ask questions:

NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

**NSC Cardiology Inc – [www.heartdrsingh.com](http://www.heartdrsingh.com)  
Dr. Narendra Singh Dr Jason Reingold**

**FINANCIAL POLICY**

We are all aware of the crisis to healthcare financing nationwide. Quality, personalized medical services may sometimes be expensive and we are working hard to contain costs on your behalf. There is much misunderstanding regarding the role of insurance and other “Third Party Payors” in the process. The following is an attempt to explain our policies in this regard:

2. Services are provided to patients, not to insurance companies. Private practice medicine is Fee-For-Service and implies a contract between patient and provider.
3. Insurance contracts are between companies and beneficiaries (patients) for reimbursement of certain covered expenses.
4. In cases where we do have contracts with managed care providers we will comply with their regulations. In other words, we will be filing your claims with the appropriate carriers and collecting your copay at the time of services.
5. Patients covered under HMO or PPO are responsible for their copay at the time of service. They are also responsible for any portion of charges designated by the insurance company.
6. In order for our business office to file your insurance correctly, you must give the receptionist a copy of your most current insurance card along with your referral number.
7. If your HMO policy requires you to have a referral number, you are responsible to provide the number at time of services.
8. Patients electing to be seen out of network will be responsible for payment at time of services.
9. Patients covered under Medicaid must present current card and copay when applicable.
10. Recipients of medical care are expected to pay for those services whether covered by insurance or not. Insurance coverage is determined by your contract with the company.
11. For certain services (i.e., Procedures, Hospitalizations) we will assist you by filing a claim on your behalf to your insurance company. Bills not paid by insurance remain the responsibility of the patient.
12. In situations of severe financial hardship, this office will consider making special arrangements on a case-by-case basis. Please discuss this with our office manager immediately if you feel it applies to you.
13. We are all here to serve. If you have remaining questions, our staff is ready to help find the answers.
- 14. If you are seen by Dr Reingold please note that you will be billed by Georgia Integrative Cardiology, LLC.**

I hereby understand the financial policy of this office.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**NSC Cardiology Inc – [www.heartdrsingh.com](http://www.heartdrsingh.com)**

**Dr. Narendra Singh Dr Jason Reingold**

**5400 Laurel Springs Parkway, Ste 1401 & 1402 Johns Creek, GA, 30024**

**1100 Northside Forsyth Dr, Ste 345, Cumming, GA, 30041**

**Phone - 678-208-0165 Fax -888-814-0852**

**REQUEST FOR RELEASE OF MEDICAL RECORDS**

This form to be used if we need to get records from a previous physician or previous hospital stay

**TO :**  NAHVC  AHS  GCPC  Other

**I hereby request that all my medical records be released to NSC Cardiology Inc promptly.**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

Georgia law, (O.C.G.A. § 31-33-2(a)(2)), requires a physician to provide a current copy of the record to the patient under most circumstances. Also, O.C.G.A § 31-33-2(b) allows a patient or his/her designee to receive a copy of the requested record(s).

**PLEASE FAX TO 888-814-0852**

**OR E-Mail to [lindsey@nsccardiology.com](mailto:lindsey@nsccardiology.com)**