PATIENT DATA SHEET

NORTHPOINTE HEART CENTER

Main Number: (248) 545-0070

PERSONAL DATA	***ADDRESS***
LAST NAME _____	STREET _____
FIRST _____	APT # _____ CITY _____
DATE OF BIRTH _____ GENDER _____	STATE _____ ZIP _____
MARRIED _____ SINGLE _____ SEP _____	HOME PHONE _____
SOCIAL SECURITY NUMBER _____	ALTERNATE PHONE _____
	EMERGENCY CONTACT _____
	EMERGENCY PHONE _____
PLEASE LET US KNOW THE INDIVIDUAL(S) THAT WE MAY DISCLOSE YOUR HEALTH INFORMATION TO (IN THE FORM OF PHONE DISCUSSION / MESSAGES):	*THEIR RELATIONSHIP TO YOU* _____

I GIVE MY AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING:

_____

_____

_____ _____

SIGNATURE DATE

EMPLOYMENT AND REFERRAL DATA

OCCUPATION _____	REFERRED BY _____
EMPLOYER _____	PERSONAL PHYSICIAN _____
STREET _____	STREET _____
CITY/STATE_____ ZIP _____	CITY _____
WORK PHONE _____	PHONE _____
SPOUSE NAME _____	
SPOUSE EMPLOYER _____	

I AUTHORIZE THE PAYMENT OF MY INSURANCE BENEFITS DIRECTLY TO CARDIOLOGY ASSOCIATES, P.C. (d.b.a. NORTHPOINTE HEART CENTER) AND, AS SUCH, I AUTHORIZE THE RELEASE OF PERTINENT INFORMATION TO THE INSURANCE CARRIERS. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ALL SERVICES INCLUDING THOSE THAT ARE CONSIDERED REJECTED, CO-PAY, DEDUCTIBLES OR OTHER TYPE OF UNPAID SERVICES.

PATIENT'S SIGNATURE _____ DATE _____

PATIENT DATA SHEET

NORTHPOINTE HEART CENTER

PERSONAL DATA

LAST NAME _____

FIRST _____ MI _____

DATE OF BIRTH _____ GENDER _____

KNOWN ALLERGIES

_____

_____

MEDICATION DATA

PLEASE LIST ALL CURRENT MEDICATIONS:

MEDICATION	DOSE	HOW OFTEN

HEALTH STATUS DATA

PLEASE CHECK IF YOU HAVE A HISTORY OF:

- µ ANEMIA
- µ ANKLE/FEET SWELLING
- µ ANXIETY/DEPRESSION
- µ ARTHRITIS
- µ ASTHMA
- µ CANCER
- µ CHEST PAIN/TIGHTNESS
- µ DIABETES
- µ DIZZINESS/FAINTING
- µ EASY BRUISING
- µ EMPHYSEMA
- µ HEART ATTACK
- µ HEART FAILURE
- µ HIGH BLOOD PRESSURE
- µ PALPITATIONS
- µ RHEUMATIC FEVER
- µ SEIZURES
- µ SHORTNESS OF BREATH
- µ THYROID PROBLEM
- µ ULCER
- µ WEAKNESS

RISK FACTOR DATA

PARENT OR SIBLING WITH HEART DISEASE BEFORE AGE 65	µ YES µ NO
PARENT OR SIBLING WITH HIGH BLOOD PRESSURE OR DIABETES	µ YES µ NO
HAVE YOU BEEN A SMOKER?	µ YES µ NO
YEAR QUIT?	
STILL SMOKE?	µ YES µ NO
CIGARETTES/DAY?	
OUNCES OF LIQUOR CONSUMED/DAY	
BEER/WINE GLASSES/DAY	
PAST EXERCISE/STRESS TEST	µ YES µ NO
WHEN AND WHERE?	
DO YOU EXERCISE?	µ YES µ NO
WHAT KIND OF EXERCISE?	
TIMES/WEEK	
HOW LONG?	
WHEN WAS YOUR BLOOD CHOLESTEROL LEVEL LAST CHECKED?	
TOTAL CHOLESTEROL	
TRIGLYCERIDES	
LDL	
DO YOU FOLLOW A LOW CHOLESTEROL DIET?	µ YES µ NO
WEIGHT ONE YEAR AGO	

MISCELLANEOUS DATA

LIST ANY OTHER MAJOR ILLNESSES:

_____

_____

_____

LIST ANY MAJOR OPERATIONS:

_____

_____

PAST HEART SURGERY?	µ YES µ NO
WHEN?	
WHERE?	
PAST HEART CATHETERIZATION?	µ YES µ NO
WHEN?	
WHERE?	