ASSOCIATES IN CARDIOVASCULAR DISEASE *Expert care, one heart at a time.*

Dear Patient,

Thank you for choosing AICD as your Cardiology Office. We appreciate the privilege of caring for your cardiovascular needs. Our experienced team of physician and health care professionals are here to diagnose, treat and prevent a wide range of cardiovascular conditions.

Please complete the attached New Patient Forms and FAX them back to our office at

- **Springfield Office: 973-467-1675**
- **New Providence Office: 908-464-1332**

It is very important that we receive your information prior to your visit so that we can enter this information into your electronic chart in advance of your visit.

Please bring the following to your first visit:

- A list of the medications you are currently taking
- Any Lab Work you have had within the past six months . You can obtain a copy of the lab work from your primary care physician or directly from
  - **Quest** at https://Questdiagnostics.com/myquest OR
  - **LabCorp** at https://patient.labcorp.com
- Any additional medical records, pictures, or device information that is pertinent to your cardiovascular history
- Your insurance card and Photo ID
- A referral from your primary care physician if required by your insurance plan

Please be sure to arrive 20 minutes prior to your scheduled appointment.

After your first visit, we will enroll you in our Patient Portal where you will be able to view future appointments, lab results, send messages to your care team and request your health records.

You can also find additional information about our physicians and practice at our Website: www.aicdheart.com

We look forward to seeing you at your visit.

Thank you

The Physicians and Staff of Associates in Cardiovascular Disease (AICD)

SPRINGFIELD OFFICE
211 Mountain Avenue, Springfield, NJ 07081
Tel: (973) 467-0005
www.aicdheart.com

ASSOCIATES IN CARDIOVASCULAR DISEASE **PLEASE COMPLETE BOTH SIDES**

Springfield Fax to: 973-467-1675
New Providence Fax to: 908-464-1332

PATIENT NAME:_____ DATE OF BIRTH:_____ AICD PHYSICIAN:_____

DATE OF YOUR NEXT VISIT:_____ TODAYS DATE:_____

PRIMARY CARE PHYSICIAN (PCP):_____ PATIENT E MAIL:_____ PHONE:_____ CELL #:_____

DATE OF LAST VISIT TO PCP:_____ RECENT LABS DATE:_____ IF YES, WHERE? LABCORP / QUEST / OVERLOOK / MORRISTOWN

EMERGENCY CONTACT NAME AND PHONE:_____

PHARMACY NAME/TOWN:_____ MAIL AWAY PHARMACY:_____

REASON FOR YOUR VISIT :_____ WHO REFERRED YOU TO US?_____

MAY WE ACCESS YOUR MEDICATION HISTORY THROUGH OUR PHARMACY DATABASE? (Circle one) YES NO

DO YOU HAVE AND ADVANCE DIRECTIVE OR DNR? (Circle one) YES NO MAY WE LEAVE MESSAGES ON YOUR PHONE(S)? (Circle one) YES NO

SOCIAL HISTORY

Marital status:

__M__D__S__W

Ethnicity:* _____ Hispanic/Latino

_____ Not Hispanic or Latino

Race:*

___White ___Black

___Hispanic

___Asian/Pacific Islander

___Amer. Indian/Alaska Native

___Unknown/Other_____

Primary Language:_____

**Above information required by the government

Diet:

__Regular __Low salt

__Diabetic

__Low fat, low cholesterol

Exercise

__Sedentary

__Occasional

__Regular

__Active Lifestyle

__Physically unable

Please list any medications that you take here (include over-the-counter):

Use a separate sheet if more room is needed.

Medication	Dose	Frequency

Please list any allergies that you have (include Latex, Seafood, Iodine, Any Medications):

Allergy	Reaction

FAMILY HISTORY

	Cause of Death?	Age at Death?	If alive, list any cardiac and/or vascular conditions and age of onset of each.
Mother			
Father			
Brother			
Brother			
Sister			
Sister			

PATIENT NAME: _____ **PLEASE COMPLETE BOTH SIDES** **PAGE 2**

Are you experiencing any of the following?		Are you experiencing any of the following?		Have you ever had any of the following tests?	Location	Year
Shortness of Breath	____	Swollen Legs	____	__Stress Test	_____	____
Fainting/Near Fainting	____	Chest Pain/Pressure	____	__Echocardiogram	_____	____
Palpitations	____	Dizziness	____	__Carotid Ultra Sound	_____	____
Fatigue	____	Leg Pain	____	__Holter Monitor	_____	____
		Erectile Dysfunction	____			

RISKS:	PATIENT HISTORY	Age at Onset?	Surgeries/Interventions/Treatment
Tobacco	Coronary Artery Disease (CAD)		___Stent Placement
____Y____N_____Former			___CABG (Bypass)
____Packs/day			___Cardiac Catheterization
_____Year quit	Atrial Fibrillation/Arrythmias		__Cardioversion
			__Anticoagulation Therapy
High Cholesterol			__Pacemaker
____Y_____N_____Unknown			__Implantable Defibrillator
	Congestive Heart Failure (CHF)		__Valve Replacement or Repair
Diabetes	Pulmonary Embolus/ DVT		
__Y__N	Heart Valve Disorders		
_____Year Diagnosed	TIA/Stroke		
	Carotid Stenosis		
High Blood Pressure	Vascular Disease		
____Y_____N_____Unknown	Liver Problems		
_____Year Diagnosed	Sleep Apnea		
	GI Bleed/Other Bleeding Disorder		
Family History of Heart Disease	Cancer		
____Y_____N_____Unknown	Thyroid Problems		
	COPD/Asthma		
Alcohol	GERD (Reflux)		
__Y__N__Former	Depression		
____Year quit	Other		
__Daily__Rarely__Socially			
Caffeine			
__None__Coffee__Tea__Soda			

Associates in Cardiovascular Disease

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE
AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Privacy Practice Notice

I have received a copy of the Associates in Cardiovascular Disease's Notice of Privacy Practices. I hereby consent to the use or disclosure of my protected health information by, or on behalf of, Associates in Cardiovascular Disease, LLC for purposes of treatment, payment or healthcare operations. I understand that my protected health information may be used for such purposes without my written authorization.

_____ _____
Print Patient's Name **Date of Birth**

_____ _____
Signature of Patient/Parent/Guardian **Date**

Email address: _____

☐ **Check here if you do not wish voice messages to be left on your answering machine or voicemail.**

Day time phone number: _____

Emergency Contact number: _____

II. Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Associates in Cardiovascular Disease (AICD) may disclose certain documents regarding my health information to a family member, close personal friend or other caregiver because such a person is involved with my health care.

I designate the person(s) listed below as individual(s) involved with my health care provided by AICD for the purpose of making the disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time by submitting a written request to AICD.

Print Name:_____ Relationship:_____ Date of Birth:_____

Print Name:_____ Relationship:_____ Date of Birth:_____

Print Name:_____ Relationship:_____ Date of Birth:_____

_____ _____
Signature of Patient/Parent/Guardian **Date**

ATLANTIC MEDICAL GROUP
INSURANCE FORM

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date:	Address (if different):	Home phone# Cell phone#
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:					

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ATLANTIC MEDICAL GROUP or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date