



**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

PLEASE COMPLETE BOTH SIDES PAGE 2

PATIENT NAME: _____

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 _____ Fainting/Near Fainting _____ Palpitations _____ Fatigue _____	Swollen Legs _____ Chest Pain/Pressure _____ Dizziness _____ Leg Pain _____ Erectile Dysfunction _____	Stress Test _____ Echocardiogram _____ Carotid Ultra Sound _____ Holter Monitor _____		
RISKS:				
Tobacco _____ Y ___ N ___ Former _____ Packs/day _____ Year quit	PATIENT HISTORY Coronary Artery Disease (CAD) _____ Atrial Fibrillation/Arrhythmias _____	Surgeries/Interventions/Treatment _____ Stent Placement _____ CABG (Bypass) _____ Cardiac Catheterization _____ Cardioversion _____ Anticoagulation Therapy _____ Pacemaker _____ Implantable Defibrillator _____ Valve Replacement or Repair		
High Cholesterol _____ Y ___ N ___ Unknown	Congestive Heart Failure (CHF) _____ Pulmonary Embolus/ DVT _____ Heart Valve Disorders _____ TIA/Stroke _____ Carotid Stenosis _____ Vascular Disease _____ Liver Problems _____ Sleep Apnea _____ GI Bleed/Other Bleeding Disorder _____ Cancer _____ Thyroid Problems _____ COPD/Asthma _____ GERD (Reflux) _____ Depression _____ Other _____	Age at Onset? _____		
Diabetes _____ Y ___ N ___ Year Diagnosed				
High Blood Pressure _____ Y ___ N ___ Unknown _____ Year Diagnosed				
Family History of Heart Disease _____ Y ___ N ___ Unknown				
Alcohol _____ Y ___ N ___ Former _____ Year quit _____ 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?	<input type="radio"/> Yes <input type="radio"/> No	Is this patient covered by insurance?		<input type="radio"/> Yes <input type="radio"/> 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:					
<p>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.</p>					
Patient/Guardian signature				Date	