Associates in Cardiovascular Disease, LLC
New Patients - MED/SURG History Form

PLEASE BRING THIS COMPLETED FORM TO YOUR OFFICE VISIT

Name: ______________________________ **DOB:** ________________
PCP: ______________________ **AICD Cardiologist** ________________
Patient Email: __________________________ **Cell Phone:** ______________
Pharmacy: ________________ **Mail Away Pharmacy** ____________________
Allergies: ___**Latex** ___**Iodine** ___**Seafood** ___**Other** ______________________
Smoker: Yes___ **No**_____ **Former**____ **Alcohol: Social**___ **Daily**___ **Never**___

Medications	Dose	Frequency

Medical History - Cardiology	Patient History		Family History- M(mother) F(father)	Medical History - Other	Patient History		Family History- M(mother) F(father)
Aneurysm	Yes	No	M/F	Anemia	Yes	No	M/F
Atrial Fibrillation	Yes	No	M/F	Anti-Coag Therapy	Yes	No	M/F
Cardiomyopathy	Yes	No	M/F	Arthritis	Yes	No	M/F
Carotid Disease	Yes	No	M/F	Asthma	Yes	No	M/F
CHF - Diastolic	Yes	No	M/F	Autoimmune Disease	Yes	No	M/F
Congenital Heart Disease	Yes	No	M/F	Cancer	Yes	No	M/F
COPD	Yes	No	M/F	Clotting Disorder	Yes	No	M/F
Coronary Artery Disease	Yes	No	M/F	Depression	Yes	No	M/F
COVID - 19	Yes	No	M/F	Emphysema	Yes	No	M/F
Diabetes	Yes	No	M/F	Gerd (Reflux)	Yes	No	M/F
DVT/Blood Clots	Yes	No	M/F	GI Bleeding	Yes	No	M/F
Heart Attack (MI)	Yes	No	M/F	Glaucoma	Yes	No	M/F
Heart Murmur	Yes	No	M/F	Hepatitis	Yes	No	M/F
Heart Valve Problem	Yes	No	M/F	Kidney Disease	Yes	No	M/F
Hyperlipidemia/high cholesterol	Yes	No	M/F	Meningitis	Yes	No	M/F
Hypertension/high BP	Yes	No	M/F	Nerve/Muscle Disease	Yes	No	M/F
Implantable Defibrillator (ICD)	Yes	No	M/F	Osteoporosis	Yes	No	M/F
Liver Disease	Yes	No	M/F	Seizures	Yes	No	M/F
Mitral Valve Prolapse	Yes	No	M/F	Sickle Cell Anemia	Yes	No	M/F
Pacemaker	Yes	No	M/F	Sleep Apnea	Yes	No	M/F
Pulmonary Embolism	Yes	No	M/F	Substance Abuse	Yes	No	M/F
Stroke	Yes	No	M/F	Thyroid Disease	Yes	No	M/F
Vascular Disease	Yes	No	M/F	Vitamin D Deficiency	Yes	No	M/F

Surgical History - Cardiology		
Cardiac Catheterization	Yes	No
Cardioversion	Yes	No
Coronary Bypass Surgery	Yes	No
Coronary Stent Placement	Yes	No
Valve Replacement/Repair	Yes	No

Surgical History - Non-Cardiac

KAC11/18/21

Atlantic
Health System
Atlantic Medical Group

PATIENT/FAMILY CONTACT LIST

Patient's Name: ______________________________ DOB: ____________

Contacts
People who have permission to receive detailed information about your care (PHI):

PRIMARY CONTACT

Name:
Relationship:
☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: ______ _____ ________
Home: ______ _____ ________
Other: ______ _____ ________

SECONDARY CONTACT(S)

Name:
Relationship:
☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: ______ _____ ________
Home: ______ _____ ________
Other: ______ _____ ________

Name:
Relationship:
☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: ______ _____ ________
Home: ______ _____ ________
Other: ______ _____ ________

☐ **I decline to designate a representative at this time.**

Comments/Other Information:

This form is effective upon execution and will remain in effect unless revoked by me.

Patient/Guardian Signature: ______________________________ Date: __________ Time: __________

Relationship to Patient: ______________________________

Atlantic
Health System

DT2201

MRN/HAR: ____________________

Request ID: ____________________

AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A: **Patient Information:** Today's Date: __________ Daytime Phone Number: ____________________

Patient Name: ______________________________ Date of Birth: __________

Patient's Address: ______________________________

I hereby authorize and request Atlantic Health System to release information related to treatment at (check one):

☐ Morristown Medical Center ☐ Overlook Medical Center ☐ Newton Medical Center ☐ Chilton Medical Center

☐ Hackettstown Medical Center ☐ Pharmacy ☐ Atlantic Medical Group (specify): ____________________

☐ Atlantic Visiting Nurse ☐ Other (specify): ____________________

Information to be released to (receiver): ☐ Check if the same as patient

Recipient Name/Facility/Organization: ____________________

Complete Address: ____________________

Phone Number: ____________________ Attention to: ____________________

Purpose of Release: ☐ Physician ☐ Facility ☐ Personal Use ☐ Legal ☐ Other: ____________________

Request Delivery Type *(if blank, a paper copy will be provided)*: ☐ Paper Copy ☐ Electronic Media (CD) ☐ MyChart

☐ Encrypted Email*: ____________________ ☐ Fax Number: ______________ ☐ Postal Mail ☐ Pick-Up

In the event the facility is unable to accommodate an electronic delivery as requested, an alternate delivery will be provided (e.g. paper).

****NOTE:** Choosing encrypted email delivery involves some level of risk. We are not responsible for unauthorized access to the PHI contained in this format, or any risks (e.g. virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.*

SECTION B: ☐ **I hereby authorize Atlantic Health System to obtain medical records from:**

Name: ______________________________ Fax Number: ____________________

Address: ______________________________ Dates of Service: ____________________

SECTION C: **Description of Information to be Released/Obtained:** **Dates of Service:** ____________________

☐ Abstract (most common) face sheet, discharge summary, history & physical, consult, test results, operative reports, ED

☐ Admission/Face Sheet
☐ Complete Medical Record
☐ Consultation Report
☐ Discharge Summary
☐ Cardiology/Radiology Images
☐ EEG/Sleep Reports
☐ History & Physical
☐ Immunization Record
☐ Laboratory Report
☐ Medication Record
☐ Mental Health Consult/Eval
☐ Operative Report
☐ Pathology Report
☐ Pathology Slides/Specimen
☐ Radiology Report
☐ ______________
☐ ______________
☐ ______________

Special Instructions: ____________________

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type:

________ HIV/AIDS Treatment Records ________ Psychiatric Treatment Records ________ Genetic Testing/Treatment Records

________ Treatment for Alcohol and/or Drug Abuse ________ Sexually Transmitted Diseases Testing

SECTION D: Patient Authorization: I understand that:

1. Unless revoked by me, this authorization is valid for 6 months from the date above. Revocations must be made in writing. Mail revocation to any of our locations on the back of this form. Revocation may not be made if action has already been taken in reliance on this authorization.
2. I understand the terms of this authorization are governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations, it may be amended from time to time.
3. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, insurance payment or eligibility benefits.
4. Atlantic Health System cannot guarantee that the recipient identified will not re-disclose my health information to a third party.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee, if I ask for it.

Patient/Authorized Representative or Guardian: ______________________________ Date: __________ Time: __________
(signature of minor at age or above 12 is required for certain information)

If signed by legal authorized representative, specify relationship: ____________________

Atlantic Health System Personnel Signature: ______________________________ Date: __________ Time: __________