GARDEN STATE HEART CARE

831 TENNENT ROAD
MANALAPAN NJ 07726

201 NORTH COUNTY LINE ROAD
JACKSON NJ 08627

Jatinchandra Patel, DO John Covalesky, DO Aaron VanHise,DO

2 HOSPITAL PLAZA, SUITE 450
OLD BRIDGE NJ 08857

REGISTRATION FORM

Primary Care Doctor:_____ Referring Doctor [if different]:_____

PATIENT INFORMATION

Name:[Last]_____ [First]_____ [MI]_____

Date of Birth:_____ Age:_____ Sex: _____Male ____Female

Social Security #:_____ Marital Status:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Email Address:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Employer:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____

The above information is true to the best of my knowledge. I hereby authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Garden State Heart Care, PC or my insurance company to release any information required to process my claims.

X_____ _____

Patient/Legal Guardian Signature Date

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MEDICAL HISTORY

Name:_____ DOB:_____

Height:_____ Weight:_____

Reason for Today's Visit?_____

Pharmacy:_____

Pharmacy Address:_____City:_____

ALLERGIES:_____

MEDICATIONS [include Aspirin] – Name, Dose [mg], Frequency

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

MEDICAL HISTORY

☐ Heart Attack/Heart Stents	☐ Atrial Fibrillation	☐ Sleep Apnea
☐ Congestive Heart Failure	☐ Pacemaker	☐ Kidney Disease
☐ Bypass Surgery [CABG]	☐ Blood Clots – DVT/PE	☐ Liver Disease – Hepatitis / Cirrhosis
☐ High Blood Pressure	☐ PAD – Leg Blockages	☐ Seizures
☐ High Cholesterol	☐ Lymphedema	☐ Thyroid Disorder
☐ Stroke/TIA	☐ Diabetes Mellitus	☐ Cancer

ADDITIONAL MEDICAL HISTORY

SURGERIES

PRIOR HOSPITALIZATIONS

_____ _____ _____

FAMILY HISTORY – IE BLOOD CLOTS, STROKE, HEART ATTACK

Father: _____Alive _____ Deceased Medical problems:_____

Mother: _____Alive _____ Deceased Medical problems:_____

SOCIAL HISTORY

Tobacco: _____Never ____Current Smoker _____Former Smoker – When did you quit? _____

Alcohol: _____No ____Yes – How often_____

Exercise: _____No _____Yes - How Often: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have had the opportunity to review the *Notice of Privacy Practices*, and provided a copy [if requested].

Patient Signature _____ Date _____

Patient Name _____ Date of Birth _____

Please provide the name[s] of individuals who Garden State Heart Care, PC may provide information regarding your care/condition:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

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AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

By signing below, you authorize Garden State Heart Care to obtain medical records from your doctors or hospitals.

Patient Name:_____ Date of Birth:_____

Patient Address:_____

City:_____ State:_____ Zip:_____

I hereby authorize _____
Name of physician's office/facility disclosing information

to disclose the following protected health information to:

Garden State Heart Care, PC
831 Tennent Road
Manalapan NJ 07726
Fax 732-851-4703

Information to be Disclosed:_____

Date Range of information requested: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to Garden State Heart Care. I understand that the revocation does not apply to the information that has already been released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome [AIDS], or human immunodeficiency virus [HIV], sexually transmitted diseases, tuberculosis, or genetics. Please initial here if you do NOT want this information to be released:_____

Unless otherwise revoked, this authorization will expire in 6 months or on the following date:_____

_____ _____
Patient Signature Date