



831 TENNENT ROAD
MANALAPAN NJ 07726

201 NORTH COUNTY LINE ROAD
JACKSON NJ 08627

2 HOSPITAL PLAZA, SUITE 450
OLD BRIDGE NJ 08857

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

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

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

ADDITIONAL MEDICAL HISTORY

SURGERIES

PRIOR HOSPITALIZATIONS

FAMILY HISTORY

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