ALPHARETTA CARDIOLOGY, L.L.C.
5755 North Point Parkway, Suite 270
Alpharetta, GA 30022
Telephone 678-762-0910
Fax 678-762-0920
MARLENE L. BLAISE, M.D., F.A.C.C.

Patient information

(PLEASE PRINT)

Date _____

Name _____ SSN#_____
Last Name First Name Initial

Address _____

City _____State _____Zip _____

Home Phone _____ Cell Phone _____

E-mail Address_____

Race _____ Student? Y___ N___ Sex M___ F___ NB___TG___

Age_____ DOB _____ Marital Status_____

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

How did you hear about us? _____

In case of emergency who should be notified? _____ Phone _____

Relationship to patient _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient_____ Birthdate _____ SSN# _____

Address (If different from patient's) _____ Phone _____

City _____State_____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes ___ No ___

Subscriber Name _____ Relation to Patient _____ Birthdates _____

Address (If different from patient) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ SSN# _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents covered under this plan _____

Assignment and Release

___ I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Co
and assigned directly to Dr. Blaise dba Alpharetta Cardiology LLC, all insurance benefits, if any, otherwise payable to me for services Rendered.

___ I understand that I am financially responsible for all charges whether paid by insurance or not.

___ I hereby authorize the doctor/Alpharetta Cardiology LLC, to release all information necessary to secure the payment of benefits.

___ I authorize the use of this signature on all insurance submissions.

Notice of Privacy Practices

___ I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. Please be aware that all patient health information is protected under the guidelines of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have had the opportunity to review Alpharetta Cardiology LLC's policies and procedures regarding privacy of my health information.

Notice of Financial Responsibilities

___ I am a patient of Alpharetta Cardiology, LLC. I hereby acknowledge receipt of Alpharetta Cardiology, LLC's Notice of Financial Responsibilities and Merchant Agreement.

Notice of Office Policies

___ Your initials here mean that you have read the office policy and want to continue your cardiac care with Dr. Marlene Blaise at Alpharetta Cardiology, LLC.

_____ _____ _____

Patient / Responsible Party Signature Relationship Date

Patient Name_____

Reason for visit _____

Cardiac History:

1. Do you have chest pain? If yes, answer the questions below.

   Where is it located? _____

   _____

   How long does it last? _____

   _____

   Is it related to activity? _____

   _____

   Is it associated with shortness of breath, sweats, and /or nausea? _____

   _____

   How often does it occur? _____

   _____

   Does it occur after eating? _____

   _____

2. Do you have shortness of breath?

   With activity? _____

   Without activity? _____

   Or both? _____

3. Do you have swelling in your legs?

   _____

4. Do you have irregular hearts beats? _____

5. Have you ever passed out? _____

Risk Factors:

Do you suffer from the following?

- ☐ High Blood Pressure _____
- ☐ Diabetes _____
- ☐ High Cholesterol_____

6. List all medical problems and when they first started.

_____

_____

_____

7. List all surgeries and surgery date.

_____

_____

_____

8. Other hospitalizations.

_____

_____

_____

9. Do you have any allergies? _____

If yes, what kind of reaction? _____

10. List of medications:

MEDICATION	DOSE	HOW OFTEN	MONTH/ YEAR STARTED

11. Health Habits - Check which substances you use and describe how much you use:

- ☐ Caffeine _____
- ☐ Tobacco / Vaping _____
- ☐ Drugs _____
- ☐ Other _____

Patient Name_____

12. Family History – Please provide a complete record of medical problems experienced by members of your immediate family and include their current age. If a member of your family is deceased, please indicate their approximate age when they died and the cause of death.

- ☐ Mother _____
- ☐ Father _____
- ☐ Brothers _____
- ☐ Sisters _____

13. Symptoms - Circle conditions you currently have or have had in the past year.

Fever	Sweats	Dizziness	Vomiting	Blood in Urine
Chills	Hay Fever	Nosebleeds	Vomiting Blood	Frequent Urination
Night Sweats	Headache	Bleeding Gums	Stomach Pain	Painful Urination
Weight Loss/Gain	Fainting	Hoarseness	Bowel Changes	Sexual Dysfunction
Poor Appetite	Double Vision	Persistent Cough	Diarrhea	Excessive Thirst
Depression	Blurred Vision	Indigestion	Constipation	Excessive Hunger
Forgetfulness	Vision-Flashes	Bloating	Hemorrhoids	Hot Flashes
Loss of Sleep	Vision-Halos	Difficulty Swallowing	Gas	Rectal Bleeding
Anxiety	Hearing Loss	Nausea	Rectal Bleeding	

Muscle/Joint/Bone: Pain, Weakness, Numbness/Tingling in:

Arms Hips Legs Neck Back Feet Hands Shoulder