

ALPHARETTA CARDIOLOGY, LLC
5755 North Point Parkway, Suite 270
Alpharetta, GA 30022
Telephone 678-762-0910
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MARLENE BLAISE, MD, FACC

Patient information

(PLEASE PRINT)

Date _____

Name _____ SSN _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail Address _____

Race _____ Student? Y ___ N ___ Sex M ___ F ___ TG ___ NB ___

Age _____ Date Of Birth _____ 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 _____

Pharmacy Name, Address, and Phone _____

Primary Insurance

Person Responsible for Account _____

Relation to Patient _____ Last Name First Name Initial
Date Of Birth _____ SSN _____

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

City _____ State _____ Zip Code _____

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 _____ Date Of Birth _____

Address (If different from patient) _____ Phone _____

City _____ State _____ Zip Code _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ SSN _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents covered under this plan _____

Assignment and Release

Please provide your initials at the beginning of each statement below to acknowledge that you read it.

___ 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

Please provide your initials at the beginning of the statement below to acknowledge that you read it.

___ 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

Please provide your initials at the beginning of the statement below to acknowledge that you read it.

___ 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

Please provide your initials at the beginning of the statement below to acknowledge that you read it.

___ I have read the office policy and want to continue my 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? Yes___ No___ 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? Yes___ No___ If yes, answer the questions below.

With activity? _____

Without activity? _____

Or both? _____

3. Do you have swelling in your legs? Yes___ No___

4. Do you have irregular hearts beats? Yes___ No___

5. Have you ever passed out? Yes___ No___

Risk Factors:

6. Do you suffer from the following? Yes___ No___ If yes, place an "X" near the risk factors you have

High Blood Pressure _____

Diabetes _____

High Cholesterol _____

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

8. List all surgeries and surgery date.

9. Other hospitalizations? Yes ___ No ___ If yes, provide the date and reason for hospitalization.

10. Do you have any allergies? Yes ___ No ___ If yes, please describe the reaction to your allergies?

11. List of medications:

MEDICATION	DOSE	HOW OFTEN	MONTH/ YEAR STARTED

12. Health Habits – Place an “X” near the substances you use, and describe the amount and frequency:

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

Patient Name _____

13. 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 _____

14. 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		

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

Arms Hips Legs Neck Back Feet Hands Shoulder