ALPHARETTA CARDIOLOGY, L.L.C.
3400-C Old Milton Parkway, Suite 325
Alpharetta, GA 30005
Telephone 678-762-0910
Fax 678-762-0920

MARLENE L. BLAISE, M.D., F.A.C.C.

Patient information

(PLEASE PRINT)

Date __________________

Cell Phone __________________________________ Home Phone ____________________________

E-mail Address____

Name ____ SSN#_________________________
Last Name First Name Initial

Address ____

City _______________________________________State ____________________Zip ___________________

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 or not paid by insurance.

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.

____________________________________ _______________________ ______________________

Responsible Party Signature Relationship Date

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.

____ ___________________ _________________

Signature Date Reviewed By Date

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____

Patient Name____

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	
Anxiety	Hearing Loss	Nausea	Rectal Bleeding	

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

Arms	Hips	Legs	Neck	Back	Feet	Hands	Shoulder

EXHIBIT 4
ALPHARETTA CARDIOLOGY, LLC MARLENE
L. BLAISE, MD, FACC

ACKNOWLEDGMENT OF RECEIPT "NOTICE OF PRIVACY PRACTICES"

- I hereby acknowledge that I have received a copy of the Alpharetta Cardiology LLC' "Notice of Privacy Practices."

____
Print Name of Patient

____ _______________ ________________
Signature of Patient or Patient's Authorized Representative Date Time

As the Patient's Authorized Representative, my relationship with the patient is: _______________

The Patient is unable to sign because: ____

——— ***OR*** ———

CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT

- I hereby certify that, as an employee or agent of the Alpharetta Cardiology LLC, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the Alpharetta Cardiology LLC. ' "Notice of Privacy Practices" in accordance with the policy titled "Provision of the Notice of Privacy Practices."

____
Print Name of Employee/Agent and Department

____ ___________________ ____________
Signature of Employee/Agent Date Time

Reason(s) For Not Obtaining Acknowledgment:

____

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