Sibley℠
Heart Center
CARDIOLOGY

Patient Registration Information

Name:	Date of Birth:
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Decline to provide ☐ Other	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to provide

Preferred language (if not specified, English will be chosen as your preferred language):

Contact preference: ☐ Mobile /texting ☐ Home Phone ☐ Work Phone ☐ Email (provide email address)
To receive text message, opt in by texting “Sibley” to 622622

Home Address:	Mailing Address (if different)	
Home Phone:	Mobile Phone:	Work Phone:

Reason for visit / diagnosis: ☐ Routine follow-up ☐ New problem / diagnosis________________________________

Primary Care Physician:	**Referring Physician:**

Pharmacy:
Name: Address:

Guarantor / Responsible Party (changes since last visit) ☐ N/C (no changes)

Name:	Date of Birth:

Relationship to patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other ____________________

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Home Address:	Mailing Address (if different)	
Home Phone:	Mobile Phone:	Work Phone:

Emergency Contact(s) (changes since last visit) ☐ N/C (no changes)

Name:	Phone:

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other ____________________

Home address: City: State: Zip:

Name:	Phone:

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other ____________________

Home address: City: State: Zip:

Insurance (changes since last visit) ☐ N/C (no changes)

PRIMARY INSURANCE Name:	**SECONDARY INSURANCE** Name:
Subscriber/Member ID #:	Subscriber/Member ID #:
Group #	Group #
Subscribe Name:	Subscribe Name:
Address:	Address
Employer:	Employer:
Date of Birth:	Date of Birth:
Relationship to patient:	Relationship to patient:

ALL CHARGES ARE DUE AT THE TIME OF SERVICE

- I hereby authorize Sibley Heart Center Cardiology (Sibley) to obtain records from other sources as may be needed in the treatment of this patient.
- I hereby authorize the release of information concerning this patient’s treatment to other physicians involved in the care and treatment of this patient.
- I hereby authorize payment of insurance benefits otherwise due to me to be made directly to Sibley or hospital. I understand that I am responsible for any amount not covered by the insurance company.

A copy of this information shall be as valid as the original.

____ ______________________

Signature of parent or responsible party **Date**

MRN# ______________________

Sibley Heart Center
CARDIOLOGY

New Patient Intake Form

Patient Name: **Date of Birth:**

General Cardiovascular Symptoms: Check all that apply to the patient

☐ Chest pain ☐ Cyanosis ☐ Sweating ☐ Edema (swelling) ☐ Exercise intolerance ☐ Poor appetite
☐ Inability to keep up with peers ☐ Shortness of breath at rest ☐ Shortness of breath w/mild exercise
☐ Fainting ☐ Dizziness ☐ Palpitations ☐ No concerning symptoms ☐ Other ________________________________

Review of Systems

Weight change or poor appetite	☐ Normal	☐ Abnormal	Bones / Joints	☐ Normal	☐ Abnormal
Eyes	☐ Normal	☐ Abnormal	Skin	☐ Normal	☐ Abnormal
Ears	☐ Normal	☐ Abnormal	Nervous system	☐ Normal	☐ Abnormal
Nose	☐ Normal	☐ Abnormal	Emotional/Behavioral	☐ Normal	☐ Abnormal
Throat	☐ Normal	☐ Abnormal	Blood / Lymph system	☐ Normal	☐ Abnormal
Heart /Circulation	☐ Normal	☐ Abnormal	Hormones / Glands	☐ Normal	☐ Abnormal
Stomach /Digestion	☐ Normal	☐ Abnormal	Allergic /Immunologic	☐ Normal	☐ Abnormal
Kidneys /Bladder	☐ Normal	☐ Abnormal	Respiratory	☐ Normal	☐ Abnormal

Allergies: (changes since last visit) ☐ N/C (no changes)

☐ Yes ☐ None If Yes, please list:

Immunizations up to date: ☐ Yes ☐ No ☐ Declined

Past History: (changes since last visit) ☐ N/C (no changes)

Hospitalizations, Surgeries, Major Illnesses:

Problem:	Date / Pt age:
Problem:	Date / Pt age:
Problem:	Date / Pt age:
Problem:	Date / Pt age:
Problem:	Date / Pt age:

Patient Medical History (changes since last visit) ☐ N/C (no changes)

ADHD	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No	G-tube	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Sickle cell anemia	☐ Yes	☐ No	Glenn	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Trisomy 21	☐ Yes	☐ No	Mitral valve replace	☐ Yes	☐ No
Chronic lung disease	☐ Yes	☐ No	Tuberous sclerosis	☐ Yes	☐ No	Nissen fundoplication	☐ Yes	☐ No
Congenital heart disease	☐ Yes	☐ No	Turner syndrome	☐ Yes	☐ No	Norwood	☐ Yes	☐ No
DiGeorge syndrome	☐ Yes	☐ No	Arterial switch	☐ Yes	☐ No	PDA ligation	☐ Yes	☐ No
GERD	☐ Yes	☐ No	ASD repair	☐ Yes	☐ No	PE tubes	☐ Yes	☐ No
Kawasaki disease	☐ Yes	☐ No	AVR	☐ Yes	☐ No	TOF repair	☐ Yes	☐ No
Muscular dystrophy	☐ Yes	☐ No	BT shunt	☐ Yes	☐ No	Tonsillectomy	☐ Yes	☐ No
Obesity	☐ Yes	☐ No	CAVC repair	☐ Yes	☐ No	Adenoidectomy	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No	Coarctation repair	☐ Yes	☐ No	VSD repair	☐ Yes	☐ No
Prematurity	☐ Yes	☐ No	Fontan	☐ Yes	☐ No			

Nurse signature:____
Physician signature____
Date of visit:_________________________ MRN# _____________________

Sibley Heart Center
CARDIOLOGY

New Patient Intake Form

Patient Name: **Date of Birth:**

Family Medical History: Check all that apply (changes since last visit) ☐ N/C (no changes)

Relation	Name	Age/ Status	Heart defect at birth	Heart surgery	Heart attack	High blood pressure	Stroke	Dyslipidemia	Diabetes	Obesity	Cardiomyopathy	Pacemaker	Sudden death	Long QT Syndrome	Drowning	Passing out	Seizures	Marfan's syndrome	Deafness at birth	Other
Mother																				
Father																				
Sister																				
Brother																				
Maternal Grandmother																				
Maternal Grandfather																				
Paternal Grandmother																				
Paternal Grandfather																				
OTHER																				

Social History: Check all that apply to the patient (changes since last visit) ☐ N/C (no changes)

Exercise: ☐ Occasionally ☐ Daily ☐ Competitive athlete ☐ Recreational

Diet: ☐ Usual American ☐ Low fat ☐ Low salt ☐ Vegetarian ☐ Other________________________________

Smoking: ☐ N/A ☐ No. of packs a day____________ ☐ Age started ______________________

Alcohol: ☐ N/A ☐ Type:_________________________ ☐ Amount: _________________ day/week/month

Sexual activity: ☐ N/A ☐ Yes ☐ No ☐ Currently pregnant

Current Medications: (list all medications including over the counter medications/vitamins)

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.

Does patient take antibiotics prior to dental procedures, operations or appointments? ☐ Yes ☐ No

Nurse signature:____

Physician signature____

Date of visit:_________________________

MRN# _____________________