Sibley Heart Center CARDIOLOGY

New Patient Intake Form

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:			
Primary Care Physician:		**Referring Physician:**	
Pharmacy: Name: Address:			
Guarantor / Responsible Party			
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)			
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			
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# _____

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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		

Allergies:

☐ Yes ☐ None If Yes, please list:

Immunizations up to date: ☐ Yes ☐ No ☐ Declined

Past History:

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

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# _____

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Patient Name:	**Date of Birth:**

Family Medical History: Check all that apply

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

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# _____