Gulf Coast Cardiology
Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ _____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

Health Problem Flow Sheet

Referring Physician: _____ **Personal Physician: _____**

Surgery: (List any major operations you have had)

Year	Type of Operation	Please list any Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

History of Cardiac Tests with Location:

Last Stress Test: _____ Location: _____ Last Echo: _____ Location _____
Last Cardiac Cath: _____ Location: _____ Carotid Ultrasound: _____ Location _____

History of Cardiac Implantable:

Stents: Yes ____ No ____ Pacemaker: Yes ____ No ____ Defibrillator: Yes ____ No ____

Medications & Any over the Counter Meds: (List any drugs that you take regularly with doses and frequency)

Medication Name:	Dosage / Miligrams	How Often:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (List allergies including Penicillin, Sulfa, Iodine, etc.)

_____

Social History: (Check items which apply ONLY to the patient)

Tobacco: Yes ____ No _____ If yes, how many packs per day? _____ How many years? _____
Have you quit? Yes _____ No _____ If yes, when? _____

Alcohol: Yes ___ No ____ Occasionally ____ Frequently _____ Everyday _____

Do you drink: Caffeine ____ Coffee _____ Tea _____ Cola _____ How Much? _____/cups

Family History: (Check item if an immediate blood relative has ever had any of the following):

Cancer: Breast ____ Lung ___ Colon ____ Prostate ____ Ovarian ____ Stomach ____ Brain ____

Heart Disease ____ Diabetes _____ Stroke _____ Inherited Conditions _____

Father: Living ____ Deceased ____ What age? _____ Cause: _____

Mother: Living ____ Deceased ____ What age? _____ Cause: _____

Sibling: Living ____ Deceased ____ What age? _____ Cause: _____

Sibling: Living ____ Deceased ____ What age? _____ Cause: _____

Please Only Check What Pertains to the Patient

General

Weight Gain/Loss __
Fever __
Fatigue __
Chills __

HEENT

Loss of Hearing __
Cataracts __
Tonsillitis __
Difficulty Swallowing __
Ear Infections __
Glaucoma __
Frequent Nosebleeds __
Corrective Lenses __
Dentures __
Post Nasal Drip __
Ringing in Ears __

Pulmonary

Pneumonia __
Chronic Sputum __
Bronchitis __
Asthma __
Emphysema __
Tuberculosis __
Chronic Cough __
Pleurisy __
COPD __

Cardiovascular

High Blood Pressure __
Heart Valve Disease __
Heart Failure __
Shortness of Breath __
Angina (chest pain) __
Mitral Valve Prolapse __
Varicose Veins __
Palpitations (heart racing) __
Leg pain with walking __
Atrial Fibrillation __
Heart Attack (MI) __
Blood Clot __
Coronary Artery Bypass Graft __

Gastrointestinal

Gastritis Peptic Ulcer Disease __
Blood in Stool or Vomitus __
Change in Bowel Habits __
Hemorrhoids __
Diverticulosis __
Hiatal Hernia __
Hepatitis __
Loss of Appetite __
Diarrhea __
Tar like Stools __
Reflux __
Crohn's Disease __
Gas Pain __
Constipation __
Change in Stools __
Gallstones __
Colitis __
Nausea __
Vomiting __

Genitourinary

Kidney Stone __
Prostate Trouble __
Kidney or Bladder Infections __
Difficulty Voiding __
Blood in Urine __

Musculoskeletal

Arthritis __
Back Pain __
Ankle Swelling __
Limitation of Range __
Limitation of Motion __

Neuro/Psych

Stroke __
TIA __
Seizure __
Migraines __
Depression __
Mental Illness __

Endocrine

Diabetes (Insulin/Non-Insulin) __
Heat or Cold Tolerance __
Thyroid Problems __
Loss of Hair __
Goiter __
Change in Voice __

Anesthesia

Reactions __
Nausea __
Vomiting __

Other Medical Problems:

_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____