Welcome to Kishwaukee Cardiology Associates

Date: _____ Soc. Sec. #: _____

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City, State, Zip: _____

Birth date: _____ Home Phone: _____

Work Number: _____ Cell Number: _____

Sex: ☐ Male ☐ Female Marital Status: _____

Employer: _____ Occupation: _____

How were you referred to our office:
☐ Self referred ☐ Physician Referral ☐ Other: (please specify) _____

Who is your primary physician? _____

Phone #: _____ City & State: _____

In case of emergency, whom should we contact? _____

Phone: _____ Relationship: _____

Which pharmacy do you prefer? _____ City: _____

E-mail Address: _____

Would you be interested in receiving e-newsletters throughout the year? ☐ Yes ☐ No

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Person responsible for Acct: _____

Relationship: _____ Phone: _____

Address: (if different from above) _____

City, State, Zip: _____

Birth date: _____ Soc. Sec. #: _____

Employed By: _____ Occupation: _____

Insurance Company: _____

I.D. #: _____ Group #: _____

Kishwaukee Cardiology Associates
2530 Hauser Ross Drive Suite 100 Sycamore, IL 60178
· Phone: (815) 748-7076· Fax: (815) 748-7070

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Kishwaukee Cardiology Associates Notice of Privacy Practices.

Signature of Patient or Guardian Date

STATEMENT OF FINANCIAL RESPONSIBILITY

If at any time an insurance claim is filed on my behalf, or on behalf of a family member, I authorize the following:

I authorize the release of any medical or other information necessary to process my medical claim. I also authorize payment of medical benefits to the physician or provider of the services described in the claim.

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

Signature of Patient or Responsible Party Date

Medical History

Please list any medical conditions you have been diagnosed with in the past, including non-cardiac ones. (Ex. Asthma, high blood pressure, cancer, etc.)

Year	*Diagnosis*	*Physician*

Surgical History

Year	*Procedure*

Family History

Please list any known family medical conditions. Please include any information on heart disease, high blood pressure/cholesterol, heart attack, stroke/TIA, pacemaker/defibrillator, obesity, thyroid disease, cancer, etc.

	Conditions	*Alive/Age*
Mother		
Father		
Siblings		
Children		

Social History

Have you ever smoked?		YES	NO
	How many years have/did you smoked?		
	How much did you smoke (ex. 1 pack/day)?		
	What year did you quit?		
Do you currently drink alcohol?		YES	NO
	How many drinks per week?		
How many servings of caffeine do you have daily?			

Are you currently dieting?		YES	NO
	Please describe:		
Do you exercise regularly?		YES	NO
	Please describe:		
	Days/week:		
How many hours do you sleep/night?			
	Do you snore?	YES	NO
	Do you have any trouble sleeping?	YES	NO
	Please describe:		
What is your occupation?			
	How many hours do you work?	Full Time	Part Time
	If retired, what did you do previously?		
Do you have children?		YES	NO

Allergy History

Do you have any allergies to medications?	Reaction:
Do you have any allergies to foods?	Reaction:
Do you have any environmental allergies?	Reaction:

Medication History

Please list all medications, doses, and directions. Include any over the counter medicines as well.

Medication	Dose	Directions	Reason for taking	Physician