INTERVENTIONAL CARDIOLOGY
3028 Caring Way, Ste. 4
Port Charlotte, Florida 33952
Phone: (941) 212-2748 Fax: (941) 328-8946

Chitradeep De, MD, FACC, MPH
Mayur Lakhani, MD, FACC, RPVI

Patient Registration Form

Patient Information

Last Name: _____ First Name: _____ MI: _____

Street Address: _____Apt#: _____

City: _____ State: _____ Zip code: _____

Home Phone # _____ Cell Phone # _____ Work# _____

Email Address: _____

Date of Birth: ____/____/_____ Gender: ☐ Male ☐ Female ☐ Others

SSN: _____

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Separated ☐ Partner

Race:_____ Language: _____Ethnicity: _____

Emergency Contact: _____ Relationship _____

Home Phone# _____ Cell Phone# _____

Primary Care Physician: _____ Phone# _____

Address: _____ City: _____

State: _____ Zip code: _____

Guarantor Information **(Responsible Party for Bills, IF OTHER THAN PATIENT)**

Guarantor's Name: _____ Date of Birth: ____/____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Home Phone# _____Cell Phone# _____Work#_____

Address: _____ City: _____

State: _____ Zip code: _____

Primary Insurance

Name of Primary Insurance: _____ Phone# _____

Address: _____ City: _____

State: _____ Zip code: _____

Policy# _____ Group# _____ Copay $ _____

Effective Date: ____/____/_____

Secondary Insurance

Name of Secondary Insurance: _____ Phone# _____

Address: _____ City: _____

State: _____ Zip code: _____

Policy# _____ Group# _____ Copay $ _____

Effective Date: ____/____/_____

Primary Pharmacy

Pharmacy Name: _____ Phone# _____

Address: _____ City: _____

State: _____ Zip code: _____

Medical History

Patient Name _____ Date of Birth ___/___/_____Today's Date___/___/_____

Current Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list dose and frequency if known.

Past Medical History

☐ Heart Attack	☐ High Blood Pressure	☐ Angina	☐ Stroke
☐ Diabetes Mellitus	☐ High Cholesterol	☐ Coronary Artery Dis.	☐Ulcers
☐ Cancer	☐ Chest Pain	☐ Heart Murmur	☐ Hepatitis
☐ Peripheral Artery Disease	☐ Mitral Valve Prolapse	☐HIV/AIDS	☐Asthma
☐Thyroid Problems	☐Kidney Trouble	☐Epilepsy/Seizures	☐Tumors

☐ Other_____

Pacemaker ☐ Yes ☐ No

Date of Implant ___/___/_____ Make or Model _____

Allergies

Allergies to medicine(s): _____

Allergies to Food(s) or other(s): _____

Surgical History

Date: ___/___/_____ Surgery: _____

Date: ___/___/_____ Surgery: _____

Date: ___/___/_____ Surgery: _____

Date: ___/___/_____ Surgery: _____

If you do not recall day or month it is okay. please be as accurate as possible.

Hospitalization

Date: ___/___/_____ Reason: _____

Date: ___/___/_____ Reason: _____

Date: ___/___/_____ Reason: _____

Date: ___/___/_____ Reason: _____

If you do not recall day or month it is okay. please be as accurate as possible.

Family History

Father	☐Living ☐Deceased	☐Diabetes	☐Hypertension	☐Heart Disease	☐Mental Illness	☐Cancer
Mother	☐Living ☐Deceased	☐Diabetes	☐Hypertension	☐Heart Disease	☐Mental Illness	☐Cancer
Son(s)	☐Living ☐Deceased	☐Diabetes	☐Hypertension	☐Heart Disease	☐Mental Illness	☐Cancer
Daughter(s)	☐Living ☐Deceased	☐Diabetes	☐Hypertension	☐Heart Disease	☐Mental Illness	☐Cancer
Brother(s)	☐Living ☐Deceased	☐Diabetes	☐Hypertension	☐Heart Disease	☐Mental Illness	☐Cancer
Sister(s)	☐Living ☐Deceased	☐Diabetes	☐Hypertension	☐Heart Disease	☐Mental Illness	☐Cancer

---

Social History

Smoking: ☐ Yes ☐ No ☐ Former Smoker

Duration _____ Amount _____

Alcohol: ☐ Yes ☐ No

Duration _____ Amount _____

Non-Prescription Drugs: ☐ Yes ☐ No

Name: _____ Duration _____ Amount _____

Do you have an Advanced Directive? ☐Yes ☐No *If yes, please provide a copy to the staff*

Persons Authorized to Receive your Protected Health Information, if any:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

FINANCIAL RESPONSIBILITY

PATIENT PAYMENT RESPONSIBILITY= I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL OFFICE AND HOSPITAL COPAYS, DEDUCTIBLES, AND COINSURANCES. FEES ARE DUE AT THE TIME OF SERVICE.

AUTHORIZATION AND ASSIGNMENT= I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO CHITRADEEP DE, MD. I AUTHORIZE CHITRADEEP DE, MD TO RELEASE ANY INFORMATION NECESSARY TO REQUEST CLAIM REIMBURSEMENT FROM MY INSURANCE CARRIERS.

Patient/Authorized Signature _____ Date: ____/____/_____