FETAL CARE CENTER DALLAS

CARDIOLOGY NEW PATIENT REGISTRATION FORM

Patient's Information:

Patient's Last Name: ________________________ First: _______________________ Initial: ____ Gender: ❒ Male ❒ Female

Street Address: ____

City: _________________ State: ______________ Zip: ______________ Age: _____________ Date Of Birth: ________________

Social Security: ________________________ Home Phone: ( ) _________________ Cell Phone: ( ) __________________

Work Phone: ( ) ________________________ Email: ____

Race/Ethnicity: ❒ White/Caucasian ❒ Black/African American ❒ Hispanic/Latino ❒ Asian ❒ Native American ❒ Other

Parent's Information:

Name: ______________________________________

Address: ____________________________________

City: _______________ State: ______ Zip: _________

Home Phone: ____________ Cell Phone: ____________

Work Phone: ___________ Email: _________________

Employer: ____________________________________

Social Security #: __________ Date of Birth: __________

Name: ______________________________________

Address: ____________________________________

City: ______________ State: ______ Zip: ___________

Home Phone: ___________ Cell Phone: _____________

Work Phone: ___________ Email: _________________

Employer: ____________________________________

Social Security #: ___________ Date of Birth: ________

Physician / Pharmacy Information:

Pediatrician/Primary Care: ____________________________ Phone: ( ) _______________ Fax: ( ) ________________

Referring Physician (if different): _______________________ Phone: ( ) _______________ Fax: ( ) ________________

Pharmacy Name/Location: _____________________________ Phone: ( ) _______________ Fax: ( ) ________________

Compounding Pharmacy/Location: _______________________ Phone: ( ) _______________ Fax: ( ) ________________

Insurance Information:

Primary Insurance Company: __________________________ Policy #: ________________ Group #: __________________

Claims Address: ____ Phone: ( ) _________________________________

Patient's Relationship To Insured: _______________ Policy Holder's Name (If Other Than Patient): _________________________

Subscriber's Social Security #: _________________________ Gender: ❒ Male ❒ Female Date Of Birth: _______________

Secondary Insurance Company: ________________________ Policy #: ________________ Group #: __________________

Claims Address: ____ Phone: ( ) _________________________________

Patient's Relationship To Insured: _______________ Policy Holder's Name (If Other Than Patient): _________________________

Subscriber's Social Security #: _________________________ Gender: ❒ Male ❒ Female Date Of Birth: _______________

Emergency Contact:

Name: ____ Relationship To Patient: ____________________________

Home Phone: ( ) _________________ Work Phone: ( ) _________________ Cell Phone: ( ) _________________

FETAL CARE CENTER
DALLAS

CARDIOLOGY NEW PATIENT REGISTRATION FORM

ASSIGNMENT AND RELEASE:

Please read the following and sign below:

<u>ASSIGNMENT OF BENEFITS, BILLING POLICY, AND RELEASE OF MEDICAL INFORMATION:</u>

I hereby authorize my insurance benefits to be paid directly to Fetal Care Consultants of Texas, LLC or any of its wholly owned subsidiaries. I understand that I am financially responsible for all payments not made by my insurance company, including (i) patient responsibility amounts such as co-pays and deductibles, (ii) non-covered services, (iii) payments not made because of failure to follow payers' administrative requirements (except as otherwise agreed), (iv) if plans benefits are exceeded, or otherwise. I am also responsible if my insurance company does not pay in accordance with the Texas Prompt Payment Regulations.

I authorize release of all protected health information to my insurance company to obtain payment for services.

<u>MEDICARE PATIENTS:</u>

I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits for any Medicare claim. I assign payment of Medicare benefits to my billing provider.

Signature:____ Date: ______________________________

PEDIATRIC CARDIOLOGY HEALTH INFORMATION

Name: ______________________________ **Date of Birth:** ____________ **M F**

Reason for Cardiology evaluation today: ______________________________

BIRTH HISTORY:

Birth Weight: ________ pounds_______ oz. **Gestational Age**: _______weeks

Pregnancy	**Labor/Delivery**	**Neonatal Course**
Uncomplicated	Normal	Uncomplicated
Complicated	Complicated by C-section	Complicated

Explain: ______________________________

____

PAST MEDICAL HISTORY:

Medical Conditions:(ex: Asthma, Diabetes, ADHD)______________________________

Prior hospitalizations? No Yes Explain: ______________________________

Prior Surgeries? No Yes Explain: ______________________________

Current Medications: **None**

____

____

Allergies to Medications: No Yes (If Yes, please list with reaction) ______________________________

Immunizations : Up to date Not up to date ______________________________

Developmental Concerns:______________________________

DIET & FEEDING HISTORY

Regular Diet for Age (> 1 year old)

Tube Feeds Amount Per Feeding __________ml ________oz Feeds Every __________hrs

(One year of age and younger)

□ **Formula:** Amount Per Feeding ________oz Feeds Every __________ hr

□ **Breastfed:** Feeds Every ________ hr Duration of feeds __________ mins

Any difficulty Feeding?: □ **Yes** □ **No**

		(Check all that apply)	**Explain**
□		Tires With Feeding	
□		Tachypnea With Feeding	
□		Diaphoresis With Feeding	
□		Other	

Fetal Care Consultants, LLC. 7777 Forest Ln, Suite C742 Dallas TX 75230
Phone 972-566-5600 Fax 972-566-5680

Name: ______________________ **Date of Birth:** ______________________

FAMILY HISTORY:

(Check all that apply)	Relationship to Patient
☐ Congenital Heart Disease	☐ Marfan syndrome
☐ Sudden Death	☐ Ehler- Danlos
☐ Arrhythmia	☐ Long QT syndrome
☐ Cardiomyopathy-Dilated	☐ Congenital deafness
☐ Cardiomyopathy-Hypertrophic	☐ High Cholesterol
☐ Coronary Artery Disease	☐ Epilepsy or Seizure disorder
☐ Hypertension (High Blood Pressure)	☐ Mental Retardation
☐ Diabetes	☐ Learning or attention problems
☐ Heart Attack before age 50	
☐ Murmurs	

Patient adopted, no family history known

SOCIAL HISTORY:

Patient lives with? (Check all that apply)
☐ Mother ☐ Father ☐Sister(s) ☐Brother(s) ☐Grandparents ☐Other ____________

Smokers in household?
☐Mother ☐ Father ☐Sister(s) ☐ Brother(s) ☐Grandparents ☐ Other ____________

Attends school or daycare? No ☐Yes: What Grade?: ______________________

Exercise

(Check all that apply)

☐		Regular (on own)	
☐		Regular (at PE)	
☐		Sedentary	
☐		Restricted	
☐		Competitive	List Sports:

General

(Check all that apply)

☐		Tobacco Use	
☐		Alcohol Use	
☐		Illicit Drug Use	
☐		Supplements Use	

Name: ______________________ **Date of Birth:** ______________

REVIEW OF SYSTEMS

(Please check if **the patient** has a history of any of the following)

General:	☐ Weakness	☐ Fatigue	☐ Fever
	☐ Appetite change	☐ Weight Loss	☐ Weight Gain
HEENT:	☐ Eye Drainage	☐ Double Vision	☐ Trouble Seeing
	☐ Corrective Lenses	☐ Nasal Congestion	☐ Ear Pain
	☐ Hearing Issues	☐ Nosebleeds	☐ Gum Bleeding
	☐ Teething	☐ Facial Swelling	☐ Snoring
Cardiovascular:	☐ Fast Heart Rate	☐ Chest Pain	☐ Murmur
	☐ Irreg. Heart rate	☐ Palpitations	☐ Syncope (fainting)
GI:	☐ Diarrhea	☐ Constipation	☐ Nausea
	☐ Vomiting	☐ Abdominal Pain	☐ Blood in Stool
GU:	☐ Frequent Urination	☐ Blood in Urine	
Musculoskeletal	☐ Joint Pain & Swelling	☐ Back Pain	☐ Stiffness
	☐ Muscle Pain	☐ Scoliosis	☐ Swelling- hands & feet
Derm:	☐ Rash	☐ Skin Sores	☐ Hair Loss
	☐ Nail Changes		
Neurological:	☐ Weakness	☐ Seizures	☐ Numbness
Endo:	☐ Excessive Thirst	☐ Unexplained Weight Gain	☐ Unexplained Weight Loss
Chest/ Pulmonary	☐ Cough	☐ Frequent Pneumonia	☐ Chest Tightness
Hematology	☐ Anemia	☐ Easy bruising/ bleeding	
Endocrine	☐ Excessive sweating	☐ Excessive thirst/hunger	☐ Temp intolerance

______________________________ ***Date*** ______________

Signature of Individual Completing Form

Relation to Patient: (Please check) ☐ Self ☐ Parent ☐ Guardian

Date: ______________ **Reviewed by:** ______________________ **MD**