ALPHARETTA CARDIOLOGY, LLC
5755 North Point Parkway, Suite 270
Alpharetta, GA 30022
Telephone 678-762-0910
Fax 678-762-0920
MARLENE BLAISE, MD, FACC

Patient information

(PLEASE PRINT)

Date ______________________

Name ____ SSN ______________________
Last Name First Name Initial

Address ____

City _______________________________________ State ___________________Zip Code ___________

Home Phone ________________________________ Cell Phone ________________________________

E-mail Address____

Race ______________ Student? Y___ N___ Sex M___ F___ TG___NB___

Age_______________ Date Of Birth ___________________ Marital Status_______________

Patient Employed by ____ Occupation ________________

Business Address ____ Business Phone ____________

How did you hear about us? ____

In case of emergency who should be notified? ______________________ Phone ___________________

Relationship to patient ____

Pharmacy Name, Address, and Phone ____

Primary Insurance

Person Responsible for Account ____
Last Name First Name Initial

Relation to Patient______________________ Date Of Birth ___________ SSN ______________________

Address (If different from patient's) ______________________________ Phone ___________________

City _________________________________ State__________________ Zip Code _________________

Person Responsible Employed by ________________________________ Occupation ________________

Business Address ____ Business Phone ____________

Insurance Company ____

Contract # ____________________________ Group # _______________ Subscriber # _______________

Name of other dependents covered under this plan ____

Additional Insurance

Is patient covered by additional insurance? Yes ___ No ___

Subscriber Name ____________________Relation to Patient ____________ Date Of Birth __________

Address (If different from patient) _____________________________ Phone ____________________

City __________________________________ State _____________ Zip Code __________________

Subscriber Employed by ____________________________________ Business Phone ____________

Insurance Company ____ SSN _____________________

Contract # _____________________________ Group # __________ Subscriber # _______________

Name of other dependents covered under this plan ____

Assignment and Release

Please provide your initials at the beginning of each statement below to acknowledge that you read it.

___ I, the undersigned certify that I (or my dependent) have insurance coverage with ________________
Name of Insurance Co
and assigned directly to Dr. Blaise dba Alpharetta Cardiology LLC, all insurance benefits, if any, otherwise payable to me for services Rendered.

___ I understand that I am financially responsible for all charges whether paid by insurance or not.

___ I hereby authorize the doctor/Alpharetta Cardiology LLC, to release all information necessary to secure the payment of benefits.

___ I authorize the use of this signature on all insurance submissions.

Notice of Privacy Practices

Please provide your initials at the beginning of the statement below to acknowledge that you read it.

___ I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. Please be aware that all patient health information is protected under the guidelines of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have had the opportunity to review Alpharetta Cardiology LLC's policies and procedures regarding privacy of my health information.

Notice of Financial Responsibilities

Please provide your initials at the beginning of the statement below to acknowledge that you read it.

___ I am a patient of Alpharetta Cardiology, LLC. I hereby acknowledge receipt of Alpharetta Cardiology, LLC's Notice of Financial Responsibilities and Merchant Agreement.

Notice of Office Policies

Please provide your initials at the beginning of the statement below to acknowledge that you read it.

___ I have read the office policy and want to continue my cardiac care with Dr. Marlene Blaise at Alpharetta Cardiology, LLC.

___________________________________ ______________________ __________________

Patient / Responsible Party Signature Relationship Date

Patient Name____

Reason for visit ____

Cardiac History:

1. Do you have chest pain? Yes___ No___ If yes, answer the questions below.

   Where is it located? ____

   ____

   How long does it last? ____

   ____

   Is it related to activity? ____

   ____

   Is it associated with shortness of breath, sweats, and /or nausea? _____________________________

   ____

   How often does it occur? ____

   ____

   Does it occur after eating? ____

   ____

2. Do you have shortness of breath? Yes___ No___ If yes, answer the questions below.

   With activity? ____

   Without activity? ____

   Or both? ____

3. Do you have swelling in your legs? Yes___ No___

   ____

4. Do you have irregular hearts beats? Yes___ No___

   ____

5. Have you ever passed out? Yes___ No___

   ____

Risk Factors:

6. Do you suffer from the following? Yes___ No___ If yes, place an “X” near the risk factors you have

- ☐ High Blood Pressure ____
- ☐ Diabetes ____
- ☐ High Cholesterol____

7. List all medical problems and when they first started.

____

____

____

8. List all surgeries and surgery date.

____

____

____

9. Other hospitalizations? Yes___ No___ If yes, provide the date and reason for hospitalization.

____

____

____

10. Do you have any allergies? Yes___ No___ If yes, please describe the reaction to your allergies?

____

____

11. List of medications:

MEDICATION	DOSE	HOW OFTEN	MONTH/ YEAR STARTED

12. Health Habits – Place an "X" near the substances you use, and describe the amount and frequency:

- ☐ Caffeine ____
- ☐ Tobacco / Vaping ____
- ☐ Drugs ____
- ☐ Other __________________________ ____

Patient Name____

13. Family History – Please provide a complete record of medical problems experienced by members of your immediate family and include their current age. If a member of your family is deceased, please indicate their approximate age when they died and the cause of death.

- ☐ Mother ____
- ☐ Father ____
- ☐ Brothers ____
- ☐ Sisters ____

14. Symptoms - Circle conditions you currently have or have had in the past year.

Fever	Sweats	Dizziness	Vomiting	Blood in Urine
Chills	Hay Fever	Nosebleeds	Vomiting Blood	Frequent Urination
Night Sweats	Headache	Bleeding Gums	Stomach Pain	Painful Urination
Weight Loss/Gain	Fainting	Hoarseness	Bowel Changes	Sexual Dysfunction
Poor Appetite	Double Vision	Persistent Cough	Diarrhea	Excessive Thirst
Depression	Blurred Vision	Indigestion	Constipation	Excessive Hunger
Forgetfulness	Vision-Flashes	Bloating	Hemorrhoids	Hot Flashes
Loss of Sleep	Vision-Halos	Difficulty Swallowing	Gas	Rectal Bleeding
Anxiety	Hearing Loss	Nausea	Rectal Bleeding	

Muscle/Joint/Bone: Pain, Weakness, Numbness/Tingling in:

Arms Hips Legs Neck Back Feet Hands Shoulder