Stillwater Medical Center
CARDIOLOGY CLINIC

1323 W. Sixth Ave., Suite 201 • Stillwater, OK 74074
PH: 405.533.3010 | FAX: 405.533.5314

REGISTRATION

Title: _____ **Name (Last, First, Middle):** _____ **Nickname:** _____

SSN: _____-_____-_____ **Birth Date:** _____ **Sex: M F Other:** _____
(optional)

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

Race (circle those that apply): Asian White Native American Indian Pacific Islander Hispanic
African American American Indian Multi-racial Unknown

Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino

Language: _____ **Religion:** _____

Marital Status (circle one): Single Divorced Legally Separated Married Widowed Life Partner

Email Address (patient portal and survey reasons only): _____

Employer: _____ **Local Pharmacy:** _____

Preferred Phone (circle one): Cell Home Work Alternate

Cell: _____ **Home:** _____

Work: _____ **Alternate:** _____

Primary Care Physician: _____

Other physicians or specialists involved in your care:
Physician: _____ **Location:** _____
Physician: _____ **Location:** _____
Physician: _____ **Location:** _____

Emergency Contact: **Name:** _____ **Phone:** _____

If there is a guarantor for your account, other than yourself, please notify the front office staff.

I request payment of authorized Medicare and/or commercial insurance benefits to me or on my behalf for any services furnished me by or in SMC. I authorize any holder of medical or other information about me to release to Medicare and/or commercial insurance and its agents any information needed to determine these benefits or benefits for related services. A photocopy of this release shall be considered effective and as valid as the original.

Payment in full is expected at time of services. If you are unable to pay for services, please notify the front office for payment options. For your convenience, we accept personal checks, credit cards, and cash. Any medical insurance you have is intended to protect you against financial loss, but payment in full for your care is your responsibility regardless of insurance coverage.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or the liability of another party. I will make sure that my claims are paid promptly. A photocopy of this release shall be considered effective and as valid as the original.

Signature Patient/Guarantor: _____ **Date:** _____

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STILLWATER MEDICAL CENTER
Management of Private Medical Records and Permit for Release of Medical Information
Cardiology Clinic

*Print Name*_____ *D.O.B*_____

The Notice of Privacy Practices, which explains how your health information is protected, is available at the front desk. Please let us know if you have any questions regarding the Notice of Privacy Practices by contacting our front office, or discussing with your physician.

1. I do_____ do not_____ authorize messages containing medical information to be left on my voicemail at phone number_____

2. You may _____may not_____ call me and/or leave voicemail at my workplace number_____

3. You may discuss my medical information with the following people:
   Name_____ Phone_____
   Name_____ Phone_____
   Name_____ Phone_____

Your signature indicates that you are aware of the privacy practices at the Cardiology Clinic.

_____/_____ _____ _____
Patient (or representative) signature | Relationship to patient | Date | Time

Reviewed/Revised: 6/17, 10/17 Reference: For Use On:	STILLWATER MEDICAL CENTER **Management of Private Medical Records and Permit for Release of Medical Information** Cardiology Clinic	Patient Label (Pt Name, V#, MR#, DOB, DOS, Age, Sex, Loc, Physician)

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Name: _____ **Date of Birth:** _____

Please list your allergies to medications and food. You may attach a list as well.

_____ _____

_____ _____

Are you allergic to iodine or shellfish? Yes No **Are you allergic to latex?** Yes No

Please list your current medications and any supplements. You may attach a list as well.

Medication	Dose	Route	How often?

REVIEW OF SYSTEMS

These are symptoms that you are currently having or have experienced in the last 2 weeks.
Please indicate YES by marking the circle. An empty circle indicates that you have NOT had that symptom.

CARDIAC

- o Chest pain
- o Excessive sweating
- o Syncope/passing out
- o Shortness of breath (circle appropriate)
  While sleeping Exertion Rest
- o Palpitations

VASCULAR

- o Fluid retention/swelling
- o Leg ache with activity/exertion

RESPIRATORY

- o Snoring
- o Sleep disturbances/apnea
- o Difficulty breathing while lying flat
- o Coughing up blood

PSYCHIATRIC

- o Depression
- o Hallucinations

HEMATOLOGIC

- o Anemia
- o Low platelets

ENDOCRINE

- o Goiter
- o Tremors

GASTROINTESTINAL

- o Nausea
- o Reflux (heartburn)
- o Bleeding

NEUROLOGICAL

- o Dizziness
- o Memory Loss
- o Seizures

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Name: _____ **Date of birth:** _____

PERSONAL MEDICAL HISTORY

Please only indicate if you have been diagnosed with any of the following.
Please indicate YES by marking the circle. An empty circle indicates that you have NOT had that diagnosis.

- o Abnormal aortic plaque
- o Acid reflux
- o Allergies
- o Anemia
- o Aneurysm
- o Atrial fibrillation/flutter
- o Any bleeding requiring transfusion
- o Anxiety
- o Arm circulation problem
- o Arthritis
- o Asthma
- o Blood clots
- o Cardiac arrhythmia
- o Cardiovascular disease
- o Cancer (type_____)
- o Carotid artery narrowing
- o Chemotherapy
- o Chest pain
- o Congestive heart failure
- o Coronary artery disease
- o COPD
- o Depression
- o Diabetes
- o Elevated cholesterol
- o Headache/migraine
- o Heart attack
- o Heart murmur
- o Leg circulation problem
- o Heart valve disease
- o Hepatitis/liver disease
- o High blood pressure
- o Kidney disease
- o Osteoporosis
- o Peptic ulcer disease
- o Radiation
- o Seizure disorder
- o Sleep apnea
- o Stroke/TIA in past
- o Thyroid disease
- o Transplant (type_____)

PERSONAL SURGICAL/PROCEDURE HISTORY

Please only indicate if you have had any of the following surgeries/procedures.
Please indicate YES by marking the circle. An empty circle indicates that you have NOT had that surgery/procedure.
Please indicate where you had these surgeries/procedures in the line provided.

- o Heart angioplasty/stent _____
- o CABG (coronary bypass) _____
- o Aneurysm repair _____
- o Blood vessel surgery _____
- o Heart valve surgery _____
- o Mastectomy _____
- o Defibrillator Implant _____
- o Vascular Stent _____
- o Echocardiogram _____
- o Abdominal aorta ultrasound _____
- o Other _____
- o Heart cath _____
- o Blood transfusion _____
- o Cardiac pacemaker _____
- o Carotid surgery _____
- o Dialysis _____
- o Thyroidectomy _____
- o Mastectomy _____
- o Stress test _____
- o Carotid ultrasound _____
- o Gastric bypass _____

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Name: _____ **Date of birth:** _____

FAMILY MEDICAL HISTORY

Please indicate if any of your immediate family has the following diagnoses.
Please indicate YES by marking the circle. An empty circle indicates that no family members have been diagnosed. Please note which family member on the line provided.

o Abnormal heart rhythm	_____	o Cardiomyopathy	_____
o Congestive heart failure	_____	o Diabetes	_____
o Coronary artery disease	_____	o Heart attack	_____
o Peripheral disease	_____	o Sudden death	_____
o Valvular heart disease	_____	o Syncope	_____
o Stroke	_____	o High cholesterol	_____

Social History

Please answer the following questions and fill in the blank as appropriate.

Smoking/Tobacco Usage
o Status unknown
o Never Smoker
o Former Smoker — Age quit: _____
o Current Smoker — Age started: _____
What type of tobacco: _____
How much per day: _____

Vaping Use
o Status unknown
o Never vaped
o Currently vaping — With nicotine: _____
Age started: _____
Device type: _____
How often: _____
Strength: _____
o Formerly vaped — Age stopped: _____

Caffeine Usage
o None
o Coffee — Drinks per day: _____
o Tea — Drinks per day: _____
o Soft Drinks — Drinks per day: _____
o Energy Drinks — Drinks per day: _____

Alcohol Usage
o None
o Beer — Drinks per day: _____
o Wine — Drinks per day: _____
o Liquor — Drinks per day: _____

Drug Use
o None
o Current user — Type and frequency: _____
Type and frequency: _____
o Former user — Type and frequency: _____
Type and frequency: _____