LIFEBRIDGE HEALTH
NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *LifeBridge Health Notice of Privacy Practices.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

I acknowledge receipt of the *LifeBridge Health Notice of Privacy Practices.*

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

PATIENT ACCT #: _____

LIFEBRIDGE HEALTH

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

10007

Patient's Name _____ Patient's Date of Birth _____

Patient's Street Address _____ Social Security Number _____

City, State, Zip Code _____ Phone Number _____

I, the undersigned, hereby authorize _____

☐ to **release** copies of medical records to: ☐ to **obtain** copies of medical records from:

☐ **Verbal** release only of medical information to:

Name of Person or Agency _____ ( ) Phone Number _____

Address _____ City, State, Zip Code _____ ( ) Fax Number _____

The purpose or need for such disclosure is _____

Dates of Service: _____

_____ is authorized to release the following: (Please check information to be released) The medical records to be released may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, HIV / AIDS testing, HIV / AIDS results or HIV / AIDS information.

- ☐ Abstract (Summary, Op Report, Paths, Consults, H&P, lab work)
- ☐ Emergency Room Record
- ☐ Outpatient Surgery
- ☐ Discharge Summary
- ☐ Admission History and Physical
- ☐ Consultation Report
- ☐ HIV / AIDS Report
- ☐ Doctor's Office Notes
- ☐ Operative Report / Pathology Report
- ☐ Alcohol / Detox / Drug Abuse
- ☐ X-ray, EKG, EEG, Labs, Cardiopulmonary
- ☐ Physical Therapy / OT / Speech
- ☐ Nuclear Medicine
- ☐ Clinic
- ☐ Mental Health / Psychiatry
- ☐ Other _____

_____ _____

Signature **Date** **Relationship to Patient**

_____

Witness **Date**

This authorization will expire within 1 year unless otherwise indicated. The consent to disclose information may be revoked by me at any time in writing except to the extent that action has been taken in reliance thereon, as set forth in the LifeBridge Health Notice of Privacy Practices. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative as provided in the Annotated Code of the State of Maryland, Article 4-302 (d) ***Photo Id** **may be requested at the time of release.**

MR# _____ Date Completed _____ Completed By _____ # pages _____

MR7350-501-L (12/05)

PERSONAL INFORMATION

Birthplace:	Employment:
Marital Status:	Number of children:
Do you smoke? YES No If previously, how long ago did you quit?	Do you drink alcohol? YES NO If YES, how often?
Please list your hobbies:	

DO YOU HAVE OR HAVE YOU EVER HAD (please circle YES or NO):		
High Blood Pressure	YES	NO
Heart failure or heart enlargement	YES	NO
Irregular heartbeat or palpitations	YES	NO
Shortness of breath	YES	NO
Shortness of breath with exertion	YES	NO
Trouble breathing when you lie down flat If YES, how many pillows do you use to sleep	YES	NO
Wake in the middle of the night with shortness of breath	YES	NO
Swelling of the feet or ankles	YES	NO
Recent weight gain from fluid retention	YES	NO
Fainting spells	YES	NO
Stroke or near stroke	YES	NO
Pain in your legs when you walk, due to narrowing of the arteries	YES	NO
Rheumatic fever as a child	YES	NO
Valvular disease or heart murmur	YES	NO
Inflammation of the muscle sack around the heart	YES	NO
Peptic ulcer disease	YES	NO
Have you ever vomited blood	YES	NO
Hiatal hernia	YES	NO
Blood in the stool	YES	NO
Tendency to bleed easily	YES	NO
Hepatitis	YES	NO
Any type of IV drug use	YES	NO
Blood clots in legs or lungs	YES	NO
Any kind of cancer	YES	NO
Diabetes	YES	NO
Asthma or emphysema	YES	NO
Kidney failure	YES	NO
High cholesterol		
Please list any other symptoms that you feel apply but are not listed above:		

8. Please list all current medications you are taking including dosage and frequency.

Medication Name	Dosage	Frequency

9. Are you allergic to any medications or food? YES NO
If YES, please list and state what type of reaction you had:

10. Have you ever had a reaction to: INTRAVENOUS DYE SHELLFISH IODINE (please circle)
If YES, please describe the reaction:

11. Does anyone in your family have a cardiac history? YES NO
If YES, please list their relationship to you, age of onset, and their current health:

Relationship	Age of Onset	Current Health

5. If you have had one of the following procedures, please list the date, place, and physician involved:

Procedure	Date	Place	Physician
CARDIAC CATHETERIZATION (a dye study of the arteries of the heart sometimes referred to as an ANGIOGRAM)			
ANGIOPLASTY (balloon)			
ECHOCARDIOGRAM (ultrasound of the heart)			
STRESS TEST (treadmill)			
Chest x-ray			
EKG			

6. Please list any chronic medical conditions (diabetes, high blood pressure, etc.)

7. Please list your past surgeries including date, hospital, and name of surgeon. If you don't recall the exact date, please provide the year.

Surgery	Date	Place	Surgeon

Cardiovascular Associates of MD, LLC

Ali Tabrizchi, D.O., F.A.C.C., Director
602 S. Atwood Road, Suite 100
Bel Air, MD 21014-4198
Phone: 410-638-9950 FAX: 410-638-9956
Amir Najafi, M.D., F.A.C.C.

Please complete the following questionnaire so that our physicians may best assess your needs.

Name	Date
Referring Physician & Address	Phone number
Preferred Pharmacy and Address	Phone number
Reason for today's visit (symptoms)	

1. Have you had CHEST DISCOMFORT? YES NO If yes, please answer 1a-i

   a. Describe the discomfort (sharp, dull, etc.)?
   b. How often does it occur (daily, weekly, monthly)?
   c. What precipitates or aggravates the discomfort?
   d. Does it radiate to your ARM BACK or NECK? (if yes, circle which one)
   e. Do you ever sweat during this discomfort? YES NO
   f. Do you ever become nauseated? YES NO
   g. Does it happen when you exert yourself? YES NO
   h. Does it happen when you are under stress? YES NO
   i. Does nitroglycerin help to ease the discomfort? YES NO DON'T KNOW
      If YES, how long (minutes) is it before the medication eases the discomfort? _____ minutes

2. Have you ever had a heart attack? YES NO If yes, please answer 2a-c

   a. Date:
   b. Name of Physician:
   c. Name of Hospital:

3. Have you ever had coronary bypass surgery or other type of heart surgery? YES NO If yes, please answer 3a-c

   a. Date of Surgery:
   b. Name of Surgeon:
   c. Name of Hospital:

3. Please list the most vigorous activity that you perform (i.e. walking, housework, running, etc.) and what, if anything, limits that activity (chest pain, shortness of breath, leg pain, fatigue, etc.):

CARDIOVASCULAR ASSOCIATES OF MARYLAND

PATIENT REGISTRATION FORM

Patient Name First	Middle Initial	Last	Date of Birth		Age
Home Address			City	State	Zip Code
Home Phone	Cell Phone		Email		
Social Security Number	Marital Status		Sex		
Emergency Contact Person	Phone		Relationship		
Employer	Occupation		Phone		
Employment Address					
Referring Physician	Address		Phone		
Pharmacy Name	Location		Phone		

Primary Insurance Company Name	ID or Policy #		Group/Code
Primary Insurance Company Address	Subscriber's Social Security #		Date Effective
Subscriber's Name	Cell Phone	Work Phone	Relationship to Patient
Subscriber's Address	Subscriber's Employer		Subscriber's Date of Birth
Secondary Insurance Company Name	ID or Policy #		Group/Code
Secondary Insurance Company Address	Subscriber's Social Security #		Date Effective
Subscriber's Name	Cell Phone	Work Phone	Relationship to Patient
Subscriber's Address	Subscriber's Employer		Subscriber's Date of Birth

Patient Authorization

I, _____, agree to accept legal responsibility and to promptly pay all charges when billed for the above-named patient. This includes copays, deductibles, co-insurance, and noncovered services.

- *I certify that the information I have reported with regard to my insurance coverage is correct.*
- *I authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent and/or insurance company.*
- *I permit a copy of this authorization to be used in place of the original.*
- *I hereby authorize Cardiovascular Associates of Maryland to apply for benefits on my behalf for covered serves rendered.*
- *I request that payment from my insurance carrier(s) be made directly to the above provider.*
- *I authorize the above provider to utilize medical data related to my care for statistical studies.*

PLEASE NOTE - It is YOUR RESPONSIBILITY to bring YOUR INSURANCE CARD(S) TO EVERY VISIT, A REFERRAL if necessary, and to PAY YOUR COPAY AT TIME OF SERVICE if required.

_____ Date

_____ Patient or Legal Representative

Thank you for allowing us to participate in your healthcare needs.