Mohsin Ijaz, M.D., F.A.C.C.
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ADVANCED CARDIOLOGY CARE

REGISTRATION FORM

PCP:		SPECIALIST:	
PATIENT INFORMATION			
LASTNAME FIRST NAME MIDDLE NAME			Is this your legal name? ___YES ___NO
If not, what is your legal name?	FORMER NAME	MARITAL STATUS ___SINGLE____MAR____DIV___SEP___WID	
BIRTHDATE: AGE:	SEX: ____MALE____FEMALE	Do you reside in a Nursing home or Rehab Facility? ____YES_____NO	
STREET ADDRESS:	CITY	STATE AND ZIP CODE	
CELL PHONE NUMBER ( )	HOME PHONE NUMBER ( )	WORK PHONE NUMBER ( )	
OCCUPATION	EMPLOYER	EMPLOYER PHONE	
REFFERED TO CLINIC BY:			
INSURANCE INFORMATION			
PRIMARY INSURANCE ____MEDICARE____MEDCAID____OTHER:			POLICY NUMBER:
SECONDARY INSURANCE:			POLICY NUMBER:
SUBSCRIBERS NAME **(If different from patient)**	BIRTHDATE:		RELATIONSHIP TO PATIENT:
INCASE OF EMERGENCY			
NAME:	PHONE NUMBER:	ADDRESS:	RELATIONSHIP TO PATIENT:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ADVANCED CARDIOLOGY CARE or my insurance company to release my information required to process my claim.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

PERSONAL MEDICAL HISTORY	YES	NO	PERSONAL MEDICAL HISTORY	YES	NO
ALZHEIMER'S OR DEMENTIA			ANEMIA		
ANEURISM			ANGINA		
ARTHRITIS			ASTHMA		
AUTOIMMUNE DISORDER			BLEEDING OR CLOTTING DISORDER		
BLOOD CLOTS IN LUNGS			CANCER		
CARIOVASCULAR DISEASE			CHRONIC BRONCHITIS		
CHRONIC PAIN			CONGESTIVE HEART FAILURE		
COPD (EMPHYSEMA)			CORONARY ARTERY DISEASE		
DEEP VEIN THROMBOSIS (DVT)			DEPRESSION/ANXIETY		
DIABETES			EPILEPSY OR SEIZURES		
FRACTURE/BROKEN BONES			GERD		
GENETIC DISORDER			GLAUCOMA		
GOUT			HEART ATTACK		
HEART DISEASE OR DISORDER			HEMATURIA		
HEPATITIS			HYPERTENSION/HYPOTENSION		
HIGH CHOLESTEROL			KIDNEY DISEASE		
LIVER DISEASE			LYME DISEASE		
MELANOMA			MIGRAINES/HEADACHES		
MULTIPLE SCHLEROSIS			PARKINSON'S		
PULMONARY EDEMA			SCIATICA		
SKIN CONDITION			SLEEP APNEA		
STROKE			THYROID DISORDER		
ULCERS			VARICOSE VEINS		
VISON ISSUES			OTHER:		

FAMILY HISTORY	MOM	DAD	BRO	SIS	DAUGHTER	SON	OTHER:
ALIVE							
DECEASED							
AFIB							
CARDIOVASCULAR DISEASE							
CANCER							
CONGESTIVE HEART FAILURE							
COPD							
CAD							
DEPRESSION/ANXIETY							
DIABETES							
HEART DISEASE/ABNORMALITIES							
HYPERTENSION/HYPOTENSION							
HIGH CHOLESTEROL							
KIDNEY DISEASE							
STROKE							
ULCERS							
VERICOSE VEINS							
OTHERS:							
HISTORY UNKNOWN DUE TO:							

SURGICAL HISTORY		
TYPE OF SURGERY	**DATE**	**LOCATION**

SOCIAL HISTORY	TYPE	YES	NO	HOW OFTEN
ALCOHOL USE				
SMOKING				
CAFFIENE				
ILLICIT DRUGS				
OTHER				

ALLERGIES	
ALLERGY (LIST MEDICATION/FOOD/LATEX/DYE/ETC)	**REACTION (RASH/HIVES//ITCHING/ETC)**

CURRENT MEDICATIONS	DOSE	FREQUENCY

HIPPA NOTICE OF PRIVACY PRACTICE

ADVANCED CARDIOLOGY CARE

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for ACC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).

(The Notice of Privacy Practices provided by ACC describes such uses and disclosures more completely.) I have the right to review the Notice of Privacy Practices prior to signing this consent.

ACC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to

ADVANCED CARE CARDIOLOGY
11119 Rockville Pike #100 Rockville MD 20852

With this consent, **ACC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **ACC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **ACC** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **ACC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow ACC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, ACC may decline to provide treatment to me.

_____

PRINT NAME

_____ _____

PATIENT SIGNATURE/GUARDIAN DATE