

Shashin R. Desai, M.D., F.A.C.C
Gopal Gadodia, M.D., F.A.C.C.

BOARD CERTIFIED in INTERNAL MEDICINE
CARDIOVASCULAR DISEASE
INTERVENTIONAL CARDIOLOGY

PATIENT INFORMATION

PATIENT'S NAME _____
(LAST) (FIRST) (MI) (NICKNAME)

DOB ____/____/____ SOCIAL SECURITY # ____ - ____ - ____ MARITAL STATUS _____
FEMALE
MALE

ADDRESS _____
(STREET) (CITY, STATE) (ZIP CODE)

HOME PHONE (____) ____ - ____ WORK PHONE (____) ____ - ____

NAME OF SPOUSE OR PARENT _____ PATIENT'S EMPLOYER _____

ADDRESS _____ ADDRESS _____

REFERRING PHYSICIAN _____ FAMILY DOCTOR _____ PHONE # (____) ____ - ____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. _____ POLICY # _____

NAME OF INSURED PARTY _____ DOB: _____ S.S. # ____ - ____ - ____

SECONDARY INSURANCE CO. _____ POLICY # _____

NAME OF INSURED PARTY _____ DOB: _____ S.S. # ____ - ____ - ____

FINANCIAL INFORMATION

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

SIGNED _____ DATE ____/____/____

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS AND I ASSIGN BENEFITS PAYABLE TO MEDICAL ASSOCIATES OF BREVARD FOR PROFESSIONAL SERVICES RENDERED.

SIGNED _____ DATE ____/____/____

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO MEDICAL ASSOCIATES OF BREVARD.

SIGNED _____ DATE ____/____/____

HIPAA RELEASE

I AUTHORIZE MEDICAL ASSOCIATES OF BREVARD, P.A., CARDIOLOGY, TO DISCUSS MY HEALTH CARE WITH AND/OR LEAVE A DETAILED MESSAGE ON MY ANSWERING MACHINE:

(NAME) (RELATIONSHIP)

SIGNED _____ DATE ____/____/____

Shashin R. Desai, M.D., F.A.C.C.
Gopal Gadodia, M.D., F.A.C.C.

BOARD CERTIFIED in INTERNAL MEDICINE
CARDIOVASCULAR DISEASE
INTERVENTIONAL CARDIOLOGY

Name _____
Address _____
Home Ph. (____) _____ - _____ Cell Ph. (____) _____ - _____
Business Ph. (____) _____ - _____
Referring Physician _____
Family Physician _____

AGE _____ DOB ____/____/____
 MALE FEMALE
 MARRIED SEPERATED DIVORCED
 SINGLE WIDOWED
SSN ____/____/____
Occupation _____
Do you have a Living Will? yes no

Family History:

Family member	Age (if living)	Health		List any illnesses	If deceased, cause of death	Age at death
		Good	Poor			
Father						
Mother						
Brothers or sisters						

Personal History: (Women: Don't list pregnancies.)

	Hospitalization (1)	Hospitalization (1)
Type of illness		
Month/Year Hospitalized		
Name of Hospital		
City and State		

Risk Factors:

Do you smoke? _____ How much? _____ per day
Did you smoke previously? _____
Do you drink alcohol? _____ How often? _____
Do you use recreational drugs? _____
Cholesterol level (if known) _____
Do you have high blood pressure? _____
Do you have family history of heart disease? _____
Do you have diabetes? _____

When did you last have the following?

Chest x-ray _____ EKG _____
Cardiac Catheterization _____
Mammogram _____
Sigmoidoscopy _____

Present Medications:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Drug Allergies:

1.
2.
3.
4.

Review of Systems:

Place an X before signs of symptoms which you presently have, or have had frequently.

1. EYES

- eyesight worsening
- seeing double
- cataracts

2. EARS

- hearing difficulties
- buzzing in ears

3. MOUTH

- dental problems
- easy bleeding of gums

4. NOSE

- frequent congestion
- frequent nosebleeds

5. HEAD

- frequent headaches
- painful or tender over sinuses

6. NECK

- neck pain
- lumps or swelling
- stiffness

7. THROAT

- hoarse voice
- difficulty swallowing

8. LUNGS

- wheezing
- shortness of breath
- cough which produces sputum
- cough, which produces no sputum
- coughing up blood
- history of tuberculosis
- pain when breathing

9. HEART

- attacks of racing heartbeat
- chest pain or heaviness
- dizzy spells
- swollen feet or ankles
- leg cramps produces by walking
- history of heart murmur
- shortness of breath
- difficulty sleeping

10. DIGESTIVE

- difficulty swallowing
- pain on swallowing
- heartburn
- vomiting
- stomach pains
- vomiting blood/coffee-ground-colored material
- diarrhea
- black stools
- constipation
- yellow jaundice

11. URINARY TRACT

- frequent urination
- getting up at night to urinate
- wetting pants on coughing or straining
- burning on urination
- history of kidney stones
- history of urinary tract infections

12. MUSCULOSKELETAL

- painful joints
- swollen joints
- back pain
- shoulder pains
- generalized muscle aches
- swollen/painful big toe
- morning stiffness of joints

13. SKIN

- itching/redness/rash
- bruising easily

14. NEUROLOGICAL SYSTEM

- fainting spells
- lightheadedness
- seizures/convulsions
- tremors
- sudden periodic loss of vision
- loss of memory

15. GENERAL

- recent weight loss _____ pounds
- recent weight gain _____ pounds
- recent loss of appetite
- tiring easily
- night sweats
- shaking chills
- fevers
- excessive thirst

16. Special problems or symptoms:
