Oxford Valley Cardiology Associates, P.C.

Ranga A. Rao, M.D., F.A.C.C. • Srinivas S. Atri, M.D., F.A.C.C. • Mohammed Murtaza, M.D., F.A.C.C.

370 Middletown Blvd. ■ Oxford Square - Suite 510 ■ Langhorne, Pa. 19047 ■ (215) 750-6566 ■ Fax (215) 750-7288

Dear

I am writing to confirm your appointment with Dr. on at . Our office is located behind the movie theater at the Oxford Valley Mall, in the Oxford Square section, in Langhorne.

Preparation for Your Appointment

We would like to make these recommendations to help you prepare for your appointment:

1. Complete the enclosed Patient Data form and bring it with you to your appointment. Please do not mail it. Having this paperwork completed will save time at the registration.
2. If you have an HMO insurance plan, you are responsible for getting a referral for the appointment through your Primary Care Physician.
3. Bring your insurance card/s, a photo ID (such as your Driver License), and any insurance co-payment to every appointment.
4. Bring a list of your current medications, dosages and times taken.
5. Bring a list of your current medical problems and your past medical and surgical history.
6. Prepare a list of your questions for the doctor, and bring pen and paper to make notes.
7. You may want to ask a family member or friend to accompany you to the appointment.
8. If you have made changes in your address, insurance plan, marital status, etc., please call (215) 750-6566 to update your records before the appointment.

Please contact us should you have any questions or concerns at (215) 750-6566. Otherwise we will see you at the time of your appointment. Thank you for your cooperation.

Oxford Valley Cardiology Associates, P.C.

Ranga A. Rao, M.D., F.A.C.C. • Srinivas S. Atri, M.D., F.A.C.C. • Mohammed Murtaza, M.D., F.A.C.C.

370 Middletown Blvd. ■ Oxford Square - Suite 510 ■ Langhorne, Pa. 19047 ■ (215) 750-6566 ■ Fax (215) 750-7288

PATIENT INFORMATION SHEET

Name:_____ ☐ M ☐ F Date:_____
Last First

Address: _____City/State_____ Zip_____

S.S.N.: _____D.O.B._____

Home Phone: _____Other Phone:_____

Employer:_____Work Phone:_____

Emergency Contact: _____

Relationship: _____Phone:_____

Can we share medical information regarding your care with this person? _____

Referring Physician _____Phone:_____

Primary Insurance: _____

Subscriber: _____Relation:_____

S.S.N.: _____D.O.B.:_____

Policy #: _____Group #:_____

Secondary Insurance _____

Subscriber: _____Relation:_____

Policy #: _____Group #:_____

The information I have provided is correct. I authorize the release of the medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

Signature: _____Date:_____

INFORMATION SHEET

TODAY'S DATE_____

NAME_____ AGE_____ D.O.B._____

ADDRESS_____

Marital Status S M D W TELEPHONE _____ EMERGENCY CONTACT_____
Name

Last Physical Exam *(date)*_____ Routine Exam or Illness Emergency Phone #_____

ALLERGIES *(Please list all drugs and other items causing allergic reaction)*

THE INFORMATION ON THIS FORM IS CONFIDENTIAL AND WILL ONLY BE RELEASED WITH YOUR AUTHORIZATION.

	If Living		If Deceased	
	Age	Health	Age at death	Cause
Father				
Mother				
Brother or Sister 1.				
2.				
3.				
4.				
5.				
Husband or Wife				
Son or Daughter 1.				
2.				
3.				
4.				
5.				
6.				

Has any blood relative ever had	Please circle No or Yes		Who
Cancer	No	Yes	
Tuberculosis	No	Yes	
Diabetes	No	Yes	
Heart Trouble	No	Yes	
High Blood Pressure	No	Yes	
Stroke	No	Yes	
Epilepsy	No	Yes	
Insanity	No	Yes	
Suicide	No	Yes	
Have you ever had			Year
Stress Test	No	Yes	
Cardiac Catheterization	No	Yes	
Heart Surgery	No	Yes	
Elevated Cholesterol	No	Yes	
Elevated Triglycerides	No	Yes	

PERSONAL HISTORY

ILLNESSES: *Have you ever had*
PLEASE ENCIRCLE ALL ANSWERS

Measles	No	Yes
German Measles	No	Yes
Mumps	No	Yes
Chicken Pox	No	Yes
Whooping Cough	No	Yes
Scarlet Fever or Scarlatina	No	Yes
Diphtheria	No	Yes
Smallpox	No	Yes
Pneumonia	No	Yes
Influenza	No	Yes
Pleurisy	No	Yes
Rheumatic Fever or Heart Disease	No	Yes
Arthritis or Rheumatism	No	Yes
Any bone or joint disease	No	Yes
Neuritis or Neualgia	No	Yes
Bursdis, Sciatica or Lumbago	No	Yes
Polio or Meningitis	No	Yes
Nephritis	No	Yes
Gonorrhea or Syphilis	No	Yes
Gallbladder disease	No	Yes
Anemia	No	Yes
Jaundice	No	Yes
Bladder disease	No	Yes
Epilepsy	No	Yes
Migraine headaches	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Cancer	No	Yes
High or low blood pressure	No	Yes
Collis or other bowel disease	No	Yes
Hemorrhoids or any rectal disease	No	Yes
Nervous Breakdown	No	Yes
Food, chemical or drug poisoning	No	Yes
Hay fever or Asthma	No	Yes
Hives or Eczema	No	Yes
Frequent infections or boils	No	Yes
AIDS	No	Yes
Any other disease	No	Yes

ALLERGIES: *Are you allergic to*

Penicillin or Sura	No	Yes
Aspirin, Codeine or Morphine	No	Yes
Mycins or other Antibiotics	No	Yes
Merthiolate or Mercurochrome	No	Yes
Any other drug	No	Yes
Any foods	No	Yes
Adhesive Tape	No	Yes
Nail polish or other cosmetics	No	Yes
Tetanus Antitoxin or Serums	No	Yes

INJURIES: *Have you had any*

Broken or cracked bones	No	Yes
Sprains	No	Yes
Lacerations	No	Yes
Dislocations	No	Yes
Concussion, or head injury	No	Yes
Ever been knocked unconscious	No	Yes

WEIGHT: Now_____One Year Ago_____
Maximum_____When_____

TRANSFUSIONS: *Have you ever had*

Blood or Plasma Transfusion	No	Yes

SURGERY: *Have you had*

Tonsillectomy	No	Yes
Appendectomy	No	Yes
Any other operation	No	Yes
Type _____	_____	Year
Type _____	_____	Year
Type _____	_____	Year
Do you smoke?	No	Yes
How many per day? _____		
Have you ever been advised to have any surgical operation which has not been done	No	Yes

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent or severe headaches	No	Yes
Fainting spells	No	Yes
Dizziness on change of position	No	Yes
Unconscious Spells	No	Yes
Blurred Vision	No	Yes
Double Vision	No	Yes
Spots before eyes	No	Yes
Infected eyes	No	Yes
Pain behind eyes	No	Yes
Anychange in vision	No	Yes
Do you wear glasses	No	Yes
When were they last checked	No	Yes
Earaches	No	Yes
Discharge from ears	No	Yes
Ringing In ears	No	Yes
Decrease in hearing	No	Yes
Recurrent nose bleeds	No	Yes
Recurrent head colds	No	Yes
Sinus Trouble	No	Yes
Hay Fever	No	Yes
Strange persistent odors	No	Yes
Strange taste or loss in taste	No	Yes
Persistent hoarseness	No	Yes
Difficulty swallowing	No	Yes
Enlarged glands	No	Yes
Recurrent sore throats	No	Yes
Recurrent sores in mouth	No	Yes
Soreness or bleeding of gums on brushing	No	Yes
Chest pain	No	Yes
Angina pectoris	No	Yes
Coughed up blood	No	Yes
Pain in arm(s)	No	Yes
Night sweats	No	Yes
Chronic or frequent cough	No	Yes
Chronic or frequent cough on laying down	No	Yes
Wake up at night short of breath	No	Yes
How many bed pillows do you use	_____	
Shortness of breath on:		
Walking several blocks	No	Yes
One flight of stairs	No	Yes
On laying down	No	Yes
Purple lips or fingers	No	Yes
Palpitations or fluttering of heart	No	Yes
High blood pressure	No	Yes
Swelling of hands, feet or ankles	No	Yes
At what time of day		
Leg cramps on walking or at night	No	Yes
Enlarged veins in legs	No	Yes
Recurrent stomach pain	No	Yes
Belching or heartburn	No	Yes
Relieved by food or medication	No	Yes
Appetite - Good ❑ Fair ❑ Poor ❑		
Nausea or vomiting	No	Yes
Vomited blood	No	Yes
Avoid some foods	No	Yes
What kinds		
Avoid spices	No	Yes
Abdominal cramping	No	Yes
Color of bowel movement		
Any blood in BM	No	Yes
Rectal pain with bowel movement	No	Yes
Change in size, shape or texture of BM	No	Yes
Describe		
Pain in urinating	No	Yes
Difficulty in starting urination	No	Yes
Do you get up at night to urinate	No	Yes
How many times		
Urinate more than before	No	Yes
Urinate less than before	No	Yes

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Any blood in urine	No	Yes
How many times per day do you urinate	No	Yes
Full feeling of bladder, but only small amount of urination	No	Yes
Lose urine on coughing or sneezing	No	Yes
Discharge from penis	No	Yes
Recurrent back pains	No	Yes
Backaches	No	Yes
Joint pain	No	Yes
Swelling of any joints	No	Yes
Redness or heat of any joint	No	Yes
Tingling or weakness of hands or feet	No	Yes
Muscle Spasms	No	Yes
Loss or change in sensation of hands or feet	No	Yes
Trembling of any extremity	No	Yes
Growth in neck or throat	No	Yes
Hot flashes	No	Yes
Tiredness without apparent reason	No	Yes
Brittleness of nails	No	Yes
Dryness of skin	No	Yes
Easy bruising	No	Yes
Inability to stand heat	No	Yes
Inability to stand cold	No	Yes
Change in hair texture	No	Yes
Change in skin texture	No	Yes
Any skin rash	No	Yes

Drugs: Laxatives:	never ❑	occ. ❑	freq. ❑	daily ❑
Vitamins:	never ❑	occ. ❑	freq. ❑	daily ❑
Sedatives:	never ❑	occ. ❑	freq. ❑	daily ❑
Tranquilizers:	never ❑	occ. ❑	freq. ❑	daily ❑
Sleeping pills, etc.:	never ❑	occ. ❑	freq. ❑	daily ❑
Aspirin, etc.:	never ❑	occ. ❑	freq. ❑	daily ❑
Cortisone, ACTH:	never ❑	occ. ❑	freq. ❑	daily ❑
Thyroid:	never ❑	occ. ❑	freq. ❑	daily ❑
	daily ❑	Now on _____		gr. day
Appetite depressants:	never ❑	occ ❑	freq. ❑	daily ❑

Have you ever been treated for drug habits	No	Yes
Have you ever taken insulin or tablets lor diabetes	No	Yes
Have you ever taken hormone tablets or injections	No	Yes

WOMEN ONLY - MENSTRUAL HISTORY

Age at onset _____

Regular? ❑ Yes ❑ No ❑ Varies

Cycle _____ days (from start to finish)

Flow: ❑ Heavy ❑ Medium ❑ Light

Date of last period _____

Date of last pelvic exam _____

Date of last Pap Test _____

Results: ❑ Negative ❑ Positive

Have you been hospitalized for any illness _____ No Yes

Give details:

Oxford Valley Cardiology Associates, P.C.

Ranga A. Rao, M.D., F.A.C.C. • Srinivas S. Atri, M.D., F.A.C.C. • Mohammed Murtaza, M.D., F.A.C.C.

370 Middletown Blvd. ■ Oxford Square - Suite 510 ■ Langhorne, Pa. 19047 ■ (215) 750-6566 ■ Fax (215) 750-7288

ACKNOWLEDGMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgment and Consent

This acknowledgment of notice and consent authorizes Oxford Valley Cardiology Associates, P.C. to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices: Oxford Valley Cardiology Associates, P.C. has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Mail:	Address to Attention:	Oxford Valley Cardiology Associates, P.C. Privacy Officer 370 Middletown Blvd. - Suite 510 Langhorne, PA 19047
Telephone:		215-750-6566
Facsimile:		215-750-7288

Acknowledgment and Consent

I have received the Notice of Privacy Practices for Oxford Valley Cardiology Associates, P.C. Oxford Valley Cardiology Associates, P.C. is authorized to use and disclose health information about _____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of Patient
(Or Patient's Personal Representative)

Date of receipt

Personal representative information (if applicable):

_____

Name of Personal Representative

_____

Relationship to Patient (or other authority)