

# 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.

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## 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		Has any blood relative ever had	Please circle No or Yes		Who
	Age	Health	Age at death	Cause				
Father					Cancer	No	Yes	
Mother					Tuberculosis	No	Yes	
Brother or Sister	1.				Diabetes	No	Yes	
	2.				Heart Trouble	No	Yes	
	3.				High Blood Pressure	No	Yes	
	4.				Stroke	No	Yes	
	5.				Epilepsy	No	Yes	
Husband or Wife					Insanity	No	Yes	
Son or Daughter	1.				Suicide	No	Yes	
	2.				Have you ever had			Year
	3.				Stress Test	No	Yes	
	4.				Cardiac Catheterization	No	Yes	
	5.				Heart Surgery	No	Yes	
	6.				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 Neuralgia ..... 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 <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>		
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 <input type="checkbox"/>	occ. <input type="checkbox"/>	freq. <input type="checkbox"/>	daily <input type="checkbox"/>
Vitamins:	never <input type="checkbox"/>	occ. <input type="checkbox"/>	freq. <input type="checkbox"/>	daily <input type="checkbox"/>
Sedatives:	never <input type="checkbox"/>	occ. <input type="checkbox"/>	freq. <input type="checkbox"/>	daily <input type="checkbox"/>
Tranquilizers:	never <input type="checkbox"/>	occ. <input type="checkbox"/>	freq. <input type="checkbox"/>	daily <input type="checkbox"/>
Sleeping pills, etc.:	never <input type="checkbox"/>	occ. <input type="checkbox"/>	freq. <input type="checkbox"/>	daily <input type="checkbox"/>
Aspirin, etc.:	never <input type="checkbox"/>	occ. <input type="checkbox"/>	freq. <input type="checkbox"/>	daily <input type="checkbox"/>
Cortisone, ACTH:	never <input type="checkbox"/>	occ. <input type="checkbox"/>	freq. <input type="checkbox"/>	daily <input type="checkbox"/>
Thyroid:	never <input type="checkbox"/>	occ. <input type="checkbox"/>	freq. <input type="checkbox"/>	daily <input type="checkbox"/>
		daily <input type="checkbox"/>	Now on _____	gr. day
Appetite depressants:	never <input type="checkbox"/>	occ <input type="checkbox"/>	freq. <input type="checkbox"/>	daily <input type="checkbox"/>

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
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Give details:

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## 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 acknowledgment 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 Oxford Valley Cardiology Associates, P.C.  
Attention: 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)