

Capitol Cardiology ASSOCIATES

| |
|-----------------------------------|
| Thomas Y. Ko, M.D.,F.A.C.C |
| Arroor S. Rao, M.D.,F.A.C.C |
| Jan Dixon Webber, M.D.,F.A.C.C |
| Khalid H. Ashai, M.D.,F.A.C.C |
| Michael J. Domanski, M.D.,F.A.C.C |
| Suman Vardan, M.D.,F.A.C.C |
| John P. Hakim, M.D.,F.A.C.C |

NAME: _____

DATE FIRST SEEN: _____

REFERRING PHYSICIAN: _____

DATE OF BIRTH: _____

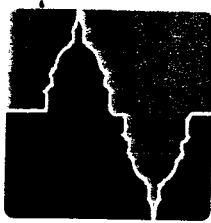
DIAGNOSIS:

1 _____
 2 _____
 3 _____
 4 _____
 5 _____

6 _____
 7 _____
 8 _____
 9 _____
 10 _____

MEDICATIONS:

ALLERGY:



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| | | | | | |
|--|--|-------------------|---------------|----------------|---------------|
| PATIENT NAME (FIRST) (MI) (LAST) | | | DATE OF BIRTH | MARITAL STATUS | SPOUSE'S NAME |
| HOME ADDRESS | APT# | CITY | STATE | ZIP CODE | HOME PHONE |
| EMPLOYER | ADDRESS | | OCCUPATION | WORK PHONE | |
| SPOUSE'S EMPLOYER | ADDRESS | | OCCUPATION | WORK PHONE | |
| FINANCIALLY RESPONSIBLE PERSON Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other <input type="checkbox"/> | Name & address if different from patient | | HOME PHONE | WORK PHONE | |
| NOTIFY IN EMERGENCY OTHER THAN SPOUSE | RELATIONSHIP | | HOME PHONE | WORK PHONE | |
| PATIENT'S SOCIAL SECURITY No. | SPOUSE'S SOCIAL SECURITY No. | PRIMARY PHYSICIAN | | RELIGION | |
| ALLERGIES (PENICILLIN), SULFA, ETC) - (IF NONE WRITE NONE) | | | | | |

INSURANCE INFORMATION

| | | | |
|---|----------------------------|-------------------|-----------|
| POLICY HOLDER Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other <input type="checkbox"/> | PRIMARY INSURANCE CO. NAME | SUBSCRIBER'S NAME | |
| INSURANCE CO. ADDRESS | | ID Policy No. | GROUP NO. |
| SECONDARY INSURANCE CO. NAME & ADDRESS | SUBSCRIBER'S NAME | ID Policy No. | GROUP NO. |

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Patients who carry health insurance should remember that professional service fees are charged to the patient and not to the insurance company. Your insurance company has no obligation to pay for my services, its obligation is to you the policy holder. Even though an insurance claim is filed you will receive a statement each month if your account has a balance due. You are responsible for payment of your account within limits of our credit policy. Although this office cannot except responsibility for checking late insurance payments or for negotiating a settlement on a disputed claim we will try to assist you with any problems concerning your insurance

Patient's Authorization

I, _____ hereby authorize CAPITOL CARDIOLOGY ASSOCIATES P.A. To apply for benefits on my behalf for covered services rendered I request payment from BC/BS of National Capitol area Blue Shield of Maryland, Medicare and/or _____ be made directly to the above-named parties
(Other insurance co name)
 (or in case of Medicare Part B benefits to myself or to the party who accepts assignment)

I certify that the information I have reported with regards to my insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any related claim to BC/BS of National Capitol Area the above named billing agent Blue Shield of Maryland (or in the case of Medicare Part B benefits to the social security Administration and Health Care

Financing Administrator and/or _____ I permit a copy of this authorization
(Other insurance co name)

to be used in place of the original. This authorization may be revoked by either me or above-named carrier at any time in writing

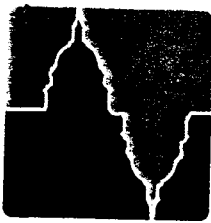
 Signature of Subscriber or beneficiary Date

 Signature of Financially Responsible Person Date

 PATIENT ACCOUNT NO.

www.capitolcardiology.com

Main Office - Medical Office Building, 8100 Good Luck Road, Suite 302, Lanham, Maryland 20706
 Phone 301-552-1200, Fax 301-552-1202
 OMNI Professional Building, 4000 Mitchellville Road, Suite B2318, Bowie, Maryland 20716
 Phone 301-552-1200, Fax 301-552-1202
 Branch Ave Office - 7700 Old Branch Avenue, Suite D203, Clinton, Maryland, 20735
 Phone 301-868-8701, Fax 301-856-3550



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**Consent for Use and Disclosure
Of Protected Health Information**

We use information that you provide to us, including health information, to carry out treatment, payment, and health care operations. Please refer to our "Notice of Privacy Practices" for a more complete description. You have the right to review the notice before signing this consent.

The terms of our Notice of Privacy Practices may change. You may obtain a revised notice from our receptionist or by calling our office administrator at (301) 552-1200.

You have the right to request that we restrict the use of your health information to carry out treatment, payment, or health care operations. We are not required to agree to the restriction. If we do agree to any restrictions, the agreement is binding on use.

You have the right to revoke this consent at any time by notifying us in writing. The revocation will not have any effect on any actions took in reliance on the consent prior to the time you revoke it.

I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment and health care operation purposes.

Patient Name (Print): _____

Signature of Patient or Patient's Representative

Date

I have received a copy of the Notice of Privacy Practices: Yes _____ No _____

Signature of Patient or Patient's Representative

Date

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Phone 301-868-8701, Fax 301-856-3550



CARDIOLOGY CONSULT

(Initial visit)

Page 3 of 3

NAME:

Date of Visit:

Primary Physician:

Reason for Visit: _____

Current Prescription Medications:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Allergies to Medications:

Social History: (check as appropriate)

- 1. Living arrangement: living alone living with family
- 2. Marital status: single married divorced widowed
- 3. Smoking: None Yes: Amount: _____ Quit Smoking: ____ yrs
- 4. Alcohol: None occasional Significant: _____
- 5. Drug use: None Yes ____ (Cocaine/ Marijuana/ Heroin). Last Use: _____
- 6. Occupation: Retired Homemaker Other _____

Family History:

- Heart disease in Father: None _____
- Heart Disease in Mother: None _____
- Heart Disease in Brother/ Sister: None _____
- Sudden/unexplained death in family member: None _____

Review of systems: (circle as appropriate)

- Constitutional: Neg; (fevers /chills /weight loss/ loss of appetite/ weakness/ weight gain)
- Eyes; Neg; (blurry vision/ glasses/ redness in eyes/ discharge from eyes/ eye pain/ blindness)
- ENT: Neg; (allergic rhinitis/ sinusitis/ sores in mouth/ hard of hearing/ vertigo)
- Respiratory: Neg; (cough/ sputum/ dyspnea/ blood with phlegm)
- G.I: Neg; (heartburn/ gas/ nausea/ vomiting/ constipation/ diarrhea/ Abdominal pain/ rectal bleeding)
- G.U: Neg; (Burning with urine/ blood with urine/ urinating at night/ incontinence of urine / prostate enlargement/ cancer prostate)
- Endocrine: Neg; (Diabetes/ low acting thyroid/ Hyperthyroidism/ Excessive thirst/ eating disorder)
- CNS: Neg; (Weakness/ numbness/ gait disorder/ Parkinson's disease/ Seizures)
- Skin: Neg; (pressure sores/ eczema/ rashes/ melanoma/ skin boils)
- MSS: Neg; (Joint pains/ back pain/ joint swellings/ muscle pains)