Fort Bend Cardiology, P.A.

Mayank Parikh, M.D., F.A.C.C.

PATIENT HISTORY

NAME____ **DATE**___________________

AGE_________ **SEX**________ **REFERRING PHYSICIAN**_____________________________

ALLERGIES TO MEDICINE____

ALLERGIES TO FOOD____

REASON FOR VISIT: *PLEASE CHECK APPROPRIATE BOX*

- ❑ Chest pain
- ❑ Shortness of Breath
- ❑ Palpitations (rapid heart beat)
- ❑ Dizziness
- ❑ Passing Out
- ❑ Swelling Feet
- ❑ Other____

PERSONAL HISTORY

Smoking	Yes _____	No_______	Duration __________	Amount _________
Alcohol	Yes _____	No_______	Duration __________	Amount _________
Non-prescription Drugs	Yes _____	No_______	Duration __________	Amount _________

FAMILY HISTORY

❑ Heart Attack or	*Father*	*Mother*	*Brother*	*Sister*
❑ Sudden Death earlier than 65 years	*Father*	*Mother*	*Brother*	*Sister*
❑ Stroke	*Father*	*Mother*	*Brother*	*Sister*
❑ Diabetes Mellitus	*Father*	*Mother*	*Brother*	*Sister*
❑ Hypertension	*Father*	*Mother*	*Brother*	*Sister*
❑ High Cholesterol	*Father*	*Mother*	*Brother*	*Sister*

PAST MEDICAL HISTORY

- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Angina
- ❑ Stroke
- ❑ Diabetes Mellitus
- ❑ High Cholesterol

PAST SURGICAL HISTORY

1.
2.
3.
4.
5.
6.

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PATIENT INFORMATION SHEET

PATIENT NAME: ____

ADDRESS: ____
(Street) (City) State (Zip Code)

HOME PHONE: ______________________ **CELLULAR/ PAGER#** ______________________

SSN: _________________________ **DRIVER'S LICSENCE OR ID#**______________________

DATE OF BIRTH: _____________________ **AGE:** _____ **SEX***:* *M / F* **MARTIAL STATUS:** *S M D W*
(*Circle One*)

REFERRING PHYSICIAN:______________________________ **PHARMACY #:** ______________________

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____________________________ **PH#.** ________________
****

EMPLOYER: __________________________________ **OCCUPATION:** _____________________________

EMPLOYER ADDRESS: _________________________ **WORK PH:** _________________________

City: _______________ **State:** _____________ **Zip Code:** ____________

SPOUSE NAME: _______________________________ **DATE OF BIRTH**: ______________________

EMPLOYER: ____________________________ **SOCIAL SECURITY #:** ________________________

WORK PHONE #: ___________________________ **CELL PHONE** #: ______________________________
****

INSURANCE INFORMATION

PRIMARY INSURANCE: _______________________________ **INSURED:** ___________________________

ADDRESS: ____

ID/POLICY NO: _________________________________ **GROUP NO:** ______________________________

2ND INSURANCE: ______________________________ **INSURED:** ______________________________

ADDRESS: ____

ID/POLICY NO: _________________________________ **GROUP NO:** ______________________________

I acknowledge and understand that I am responsible for all of the charges for the services rendered to me. If the doctor bills my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time period. I further authorize the release of any information required in the processing of the claim. I authorize my insurance benefits to be paid directly to the physician and I understand that I am responsible for any unpaid balance.

____ ___________________

SIGNATURE OF THE PATIENT OR REPONSIBLE PARTY ***DATE***