



NYU Cardiology Associates
530 First Avenue, SK-9U, New York, NY 10016
212-263-7751

WELCOME

We look forward to seeing you in Cardiology Associates Faculty Group Practice. Our goal is to provide the highest quality cardiovascular care in the most professional, patient-friendly setting. Our cardiologists are among the most respected experts in the field, and our entire staff is dedicated to making your visit stress-free and efficient.

In an effort to minimize the amount of time you spend in our waiting room and maximize your time with our cardiologists and other healthcare professionals, we ask that you please consider printing out these required forms, filling them out *prior* to your appointment and bringing them with you on the day of your appointment. If you need additional copies, you can download them directly from our website at:

<http://www.med.nyu.edu/cardiologyintakeforms>

We also ask that you sign the authorization below, confirming your agreement to receive this form by email.

I hereby grant permission to NYU Cardiology Associates to send the “new patient” email message and forms to me at the following email address.

Name:

Email address:

Signature:

Date:

Feel free to contact our office at 212-263-7751 if you have any questions.



NYU Cardiology Associates

530 First Avenue, SK-9U, New York, NY 10016
212-263-7751

Patient Information	Name				Today's date		
	Street address						
	City			State	Zip	Age	DOB
	Social Security#		Daytime Phone		Evening Phone		
	Cell Phone	Employer				Marital Status	
Emergency contact	Name				Relationship to patient		
	Daytime Phone			Evening Phone			
Primary Doctor	Primary Physician's name (if applicable)			Physician Phone/fax (if known)			
	Physician address (if known)						
Referring Doctor	Referring Physician's name (if applicable)			Physician Phone/fax (if known)			
	Physician address (if known)						
Insurance Information	Primary Insurance Company		Policy #		Group #		
	Claims Address		City	State	Zip	Phone	
	Patient's relationship to insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than Patient)			
	Subscriber's Social Security #			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB	
	Secondary Insurance Company			Policy #		Group #	
	Claims Address		City	State	Zip	Phone	
	Patient's relationship to insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than Patient)			
	Subscriber's Social Security #			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB	



SYSTEM REVIEW

NYU Cardiology Associates

530 1st Avenue, Suite 9U, New York, NY 10016
212-263-7751

Please \checkmark any that you now have or have had in the past 6 months.

<input type="checkbox"/> Headache
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Fatigue
<input type="checkbox"/> General weakness
<input type="checkbox"/> Appetite:
<input type="checkbox"/> Good
<input type="checkbox"/> Fair
<input type="checkbox"/> Poor
<input type="checkbox"/> Blurred vision or double vision
<input type="checkbox"/> Eye irritation or discharge
<input type="checkbox"/> Eye pain
<input type="checkbox"/> Discomfort looking at light
<input type="checkbox"/> Change in vision
<input type="checkbox"/> Do you wear eyeglasses/contact lenses? No / Yes
<input type="checkbox"/> Date of last exam?
<input type="checkbox"/> Earaches or discharge from ears
<input type="checkbox"/> Ringing in ears or decreased hearing
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Nasal congestion
<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Strange, persistent odors or tastes (circle if yes)
<input type="checkbox"/> Loss of taste
<input type="checkbox"/> Hoarse voice
<input type="checkbox"/> Sore throat
<input type="checkbox"/> Sores in mouth
<input type="checkbox"/> Soreness or bleeding of gums on brushing
<input type="checkbox"/> Trouble swallowing
<input type="checkbox"/> Growth in neck or throat
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Angina
<input type="checkbox"/> Pain in arm(s)
<input type="checkbox"/> Change in color of fingers
<input type="checkbox"/> Palpitations or fluttering of heart
<input type="checkbox"/> Swelling of hands, feet or ankles AM PM
<input type="checkbox"/> Leg cramps:
<input type="checkbox"/> On walking
<input type="checkbox"/> At night
<input type="checkbox"/> Shortness of breath:
<input type="checkbox"/> Wakes you up
<input type="checkbox"/> On walking several blocks
<input type="checkbox"/> On walking one flight of stairs
<input type="checkbox"/> On lying down
<input type="checkbox"/> Coughing up blood
<input type="checkbox"/> Chronic or frequent cough:
<input type="checkbox"/> Dry
<input type="checkbox"/> With phlegm
<input type="checkbox"/> Wheezing

<input type="checkbox"/> Heartburn, indigestion, belching
<input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Avoidance of any foods
<input type="checkbox"/> Abdominal pain or cramps
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation
<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Difficulty or pain with urination
<input type="checkbox"/> Do you get up at night to urinate? <input type="checkbox"/> How many times?
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Lose urine on coughing or sneezing
<input type="checkbox"/> Too frequent urination
<input type="checkbox"/> Vaginal or penile discharge
<input type="checkbox"/> Genital sores
<input type="checkbox"/> Problems with sex
<input type="checkbox"/> Backaches
<input type="checkbox"/> Joint pain or swelling
<input type="checkbox"/> Stiffness
<input type="checkbox"/> Dryness of skin
<input type="checkbox"/> Change in hair texture or skin texture
<input type="checkbox"/> Any skin rash
<input type="checkbox"/> New or change in moles or skin lesions
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Tingling or weakness of hands or feet
<input type="checkbox"/> Loss or change in sensation of hands or feet
<input type="checkbox"/> Trembling of arms, hands or legs
<input type="checkbox"/> Seizures
<input type="checkbox"/> Fainting? When?
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Inability to stand heat / cold (circle if yes)
<input type="checkbox"/> Excessive appetite
<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Enlarged glands
<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Other bleeding
<input type="checkbox"/> Hot flashes

List any other conditions for which you are treated and/or have been diagnosed:

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Patient Signature _____ Date _____

Reviewed by _____ Date _____



NYU Cardiology Associates

530 First Avenue, SK-9U, New York, NY 10016
212-263-7751

Assignment and Release	<p>Please read the following and sign below</p> <p><u>Assignment of Benefits and Release of information</u> I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf</p> <p><u>Medicare Patients</u> I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.</p> <p><u>Notice of Privacy Practices Acknowledgment</u> By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.</p> <p>Signature: _____ Date: ____/____/____</p>
-------------------------------	---

**NYU School of Medicine
Notice of Privacy Practices
Acknowledgment**

**By signing below, I acknowledge that I have been
provided a copy of the Notice of Privacy Practices.**

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Outpatient Financial Liability Statement Form

NYU Cardiology Associates

Today's Date: _____

Patient's Name: _____

Social Security #: _____

I understand that I am personally financially responsible for charges incurred for services rendered by NYU Medical Center/NYU Cardiology Associates if any of the following apply:

1) My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at NYUMC and I have not obtained such an authorization or referral or I receive services in excess of such authorization or referral.

2) My health plan determines that the services I received at NYUMC are not medically necessary.

3) My health plan is not in effect at time of service.

I also understand that I am responsible for all co-payments and co-insurance sums under my health plan.

Signature of Financially Responsible Party

Date