

# YOUR APPOINTMENT

**\* Very important – Please read carefully and completely \***  
Please use blue ink

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_ Mon Tue Wed Thu Fri Sat Arrival Time: \_\_\_\_\_ AM PM

Hollywood  Weston  Aventura (Dade County)

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Your child / you will need an EKG:

- Do not put any skin lotions, perfumes or powders.
- Female patients should wear two piece outfits.
- Wear socks

If someone other than a biological parent will be bringing a minor child for the visit:

Be sure to bring any and all documentation that gives you legal authority over the minor child. If you do not have legal documentation you must bring a signed letter with a copy of the biological parents identification, authorizing us to discuss medical issues with you.

Past medical history on the patient, including cardiac history for the biological parents and siblings (if available) needs to be known by the accompanying adult.

If your child is an **infant** we recommend that you bring:

- A warm blanket and socks to keep your baby comfortable.
- A pacifier, bottle of milk or juice, toy, and extra diaper.

## All Patients:

If you / your child had previously seen a cardiologist, bring those **medical records**. Please be sure you have your **insurance card, referral**, parent's / your **photo identification**, (such as driver's license), your co-payment, outstanding deductible and / or co-insurance (if applicable), in the amount shown on your insurance card. We also ask that you bring a **picture of your child** with his or her name and date of birth on the backside. The picture forms part of the patient chart. Some pictures may be displayed on our walls, advice a staff member if you would not like to have your child's picture displayed.

Because we believe that your time is valuable, enclosed is our **patient registration package** If the forms are complete when you arrive at our office it will allow us to expedite your child's / your registration.

A map has also been included for your convenience.

Should you have any further questions, please do not hesitate to call our office. In Broward 954-894-4115 or in Dade 305-891-4115. On the web [www.childhearts.com](http://www.childhearts.com) .

WELCOME  
Children's Cardiac Center

# PATIENT REGISTRATION

## Children's Cardiac Center

Today's Date: \_\_\_\_\_ Home Telephone: (    ) \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
LAST FIRST MIDDLE

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female Social Security #: \_\_\_\_\_

**Pediatrician or Primary Care Provider:** \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**Mother Name:** \_\_\_\_\_  Stepmother  Other  
LAST FIRST

Street Address or  Same: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation or Department: \_\_\_\_\_

Bus. Telephone: \_\_\_\_\_ Ext: \_\_\_\_\_ Pager: \_\_\_\_\_ Cellular: \_\_\_\_\_

**Father Name:** \_\_\_\_\_  Stepfather  Other  
LAST FIRST

Street Address or  Same: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation or Department: \_\_\_\_\_

Bus. Telephone: \_\_\_\_\_ Ext: \_\_\_\_\_ Pager: \_\_\_\_\_ Cellular: \_\_\_\_\_

**EMERGENCY CONTACT** Other than the information already provided

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Allergies: \_\_\_\_\_ Immunizations are up to Date:  Y  N

Pharmacy : \_\_\_\_\_ City: \_\_\_\_\_ Telephone: \_\_\_\_\_

Recent Hospitalizations:  Yes  No If yes: Reason: \_\_\_\_\_  
Date: \_\_\_\_\_ Hospital: \_\_\_\_\_

Other Cardiologist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_ Telephone: \_\_\_\_\_

Other Specialist: \_\_\_\_\_ Specialty: \_\_\_\_\_ Telephone: \_\_\_\_\_

Other Specialist: \_\_\_\_\_ Specialty: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Patient Complaints:**

Chest Pain  Yes  No  
Chest Pressure/ Tightness  Yes  No  
Dizziness  Yes  No  
Fainting  Yes  No  
Rapid Palpitations  Yes  No  
Shortness of Breath  Yes  No  
Other: \_\_\_\_\_

Patient Needs Sports Clearance  Yes  No  
Patient Needs Surgical Clearance  Yes  No  
Proposed Date for Surgery: \_\_\_\_\_ Surgeon \_\_\_\_\_  
**List Medications:** \_\_\_\_\_ Dosage \_\_\_\_\_ How Often \_\_\_\_\_  
\_\_\_\_\_ Dosage \_\_\_\_\_ How Often \_\_\_\_\_  
\_\_\_\_\_ Dosage \_\_\_\_\_ How Often \_\_\_\_\_  
\_\_\_\_\_ Dosage \_\_\_\_\_ How Often \_\_\_\_\_

More than 4 medications, please list on a separate sheet of paper.

**Family History:**  Check this box if family history is unavailable

Biological Mother: Age: \_\_\_\_\_  Healthy  Deceased Illness \_\_\_\_\_

Biological Father: Age: \_\_\_\_\_  Healthy  Deceased Illness \_\_\_\_\_

# \_\_\_\_\_ Siblings:  F  M \_\_\_\_\_ age  Healthy  Deceased Illness \_\_\_\_\_

F  M \_\_\_\_\_ age  Healthy  Deceased Illness \_\_\_\_\_

F  M \_\_\_\_\_ age  Healthy  Deceased Illness \_\_\_\_\_

F  M \_\_\_\_\_ age  Healthy  Deceased Illness \_\_\_\_\_

**Has the Patient or Any Family Member Ever Had:**

Congenital Heart Disease	<input type="checkbox"/> Patient	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____
Arrhythmia / Irregular Heart Beats	<input type="checkbox"/> Patient	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____
Increased Cholesterol	<input type="checkbox"/> Patient	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____
Diabetes	<input type="checkbox"/> Patient	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____
Hypertension	<input type="checkbox"/> Patient	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____
Heart Attack	<input type="checkbox"/> Patient	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____
Stroke	<input type="checkbox"/> Patient	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____
Sudden Unexpected Death	<input type="checkbox"/> Patient	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____
Other: _____	<input type="checkbox"/> Patient	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

*Please continue on next page*

## Health Insurance Information

Please note that the insured is the primary policy holder.

**Primary Insurance:** \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I.D. or Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Effective Date: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I.D. or Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

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### Assignment of Benefits / Release of Medical Records

I the undersigned hereby authorize the release of any information including diagnosis, psychological evaluation, HIV, drug and alcohol use information, and the records of any treatment relating to all claims for benefits submitted on behalf of myself and / or dependent (s). I further expressly agree and acknowledge that my signature on this document authorizes Children's Cardiac Center and its representatives to submit claims for benefits, for services rendered or services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and or dependent(s), and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize the above named insurance company to assign directly to Children's Cardiac Center all benefits payable. I understand that I have not been released of liability, and that I am financially responsible for all charges incurred.

Authorized Signature X \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE RETURN THIS FORM WITH YOUR DRIVERS LICENSE AND INSURANCE  
We will make copies for our records and return your cards promptly

Thank You