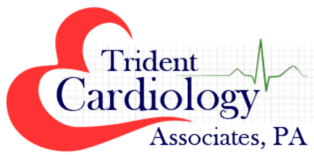


Patient Information Sheet

NAME:______________________________ SOCIAL SECURITY #:____________________

DATE OF BIRTH:______________________ LEGAL SEX: ◯MALE ◯FEMALE_____________

ADDRESS:____

CITY:______________________________ STATE:___________ ZIP:____________

HOME PHONE #:_______________________ CELL PHONE #:_________________________

MAY WE TEXT YOU FOR APPOINTMENT REMINDERS? ◯ YES ◯ NO

DO YOU WANT ACCESS TO THE PATIENT PORTAL? ◯ YES ◯ NO

EMAIL ADDRESS FOR PATIENT PORTAL:____

MARITAL STATUS: ◯SINGLE ◯MARRIED ◯DIVORCED ◯WIDOWED ◯DECLINE

RACE: ◯AFRICAN AMERICAN ◯ASIAN ◯CAUCASIAN ◯HISPANIC ◯OTHER ◯DECLINE

EMERGENCY CONTACT

CONTACT NAME:_________________PHONE #:_____________RELATIONSHIP:____________

EMPLOYMENT

EMPLOYMENT STATUS:____

PLACE OF EMPLOYMENT:____

WORK TELEPHONE #:___________________ NAME OF COMPANY:_______________________

INSURANCE INFORMATION

PRIMARY INSURANCE: ◯SELF ◯SPOUSE ◯PARENT

NAME OF INSURANCE COMPANY:____

POLICY #:____________________________ GROUP #:______________________________

(IF THIS POLICY IS UNDER YOUR PARENT/SPOUSE PLEASE FILL OUT THIS SECTION WITH THEIR INFORMATION)

SPOUSE/PARENT NAME:__________________ DATE OF BIRTH:_______________________

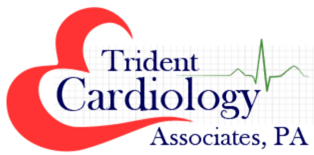
SOCIAL SECURITY #:___________________PLACE OF EMPLOYMENT:___________________

SECONDARY INSURANCE: ◯SELF ◯SPOUSE ◯PARENT

NAME OF INSURANCE COMPANY:____

POLICY #:____________________________ GROUP #:______________________________

SIGNATURE:____DATE:______________



PRIVACY INFORMATION

This section must be completed to authorize TRIDENT CARDIOLOGY ASSOCIATES PA to release/discuss your health information: List of people that we may contact on your behalf. (Example: Doctor(s), family member(s) or anyone directly participating in ongoing medical care)

FROM(MM/DD/YY)________________________ To(MM/DD/YY)__________________________

Name	Phone/Fax	Relationship

I have read and authorize TRIDENT CARDIOLOGY ASSOCIATES PA to release my health care information to the above listed people or organizations.

Signed:____Date:__________________

ACKNOWLEGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy for TRIDENT CARDIOLOGY ACCOCIATES PA.

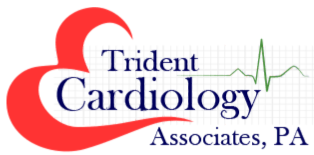
Signed:____Date:__________________

PATIENT FINANCIAL RESPONSIBILITES:

- The patient is ultimately responsible for payment of treatment and care.
- If your insurance requires a referral to a specialist, it is YOUR responsibility to get the referral before your scheduled appointment or you will be responsible for the visit.
- We will bill your insurance for you; however, the patient is required to provide the correct and updated information regarding insurance.
- Patients are responsible for payments of co-pays, deductibles, and all other procedures or treatments not covered by your insurance plan.
- Co-Pays are due at the time of service.
- Co-Insurance, deductibles, and non-covered items are due 30 days from receipt of billing. If you are unable to pay within 30 days, we will be happy to set up a payment plan with you.

I have read and understand the Financial Policy for TRIDENT CARDIOLOGY ASSOCIATES PA.

SIGNATURE:____DATE:______________



MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Trident Cardiology Associates P.A. When you schedule an appointment with Trident Cardiology Associates, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please See Our Appopintment/No Show Policy Below:

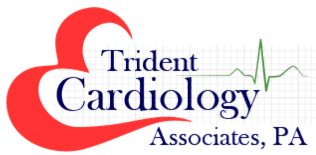
- Effective August 1st, 2021 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **AT LEAST 24 HOURS NOTICE** will be considered a **NO SHOW** and charged a **$25.00 FEE**.
- Any established patient who fails to show or cancels/reschedules an appointment with **NO 24 HOUR NOTICE** a **SECOND** time will be charged a **$50.00 FEE**
- If a **THIRD** No Show or cancellation/reschedule with no 24 hour notice should occur, the patient may be **DISMISSED** from Trident Cardiology Associates.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact out Practice Administrator, who may be able to waive the No Show Fee. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Trident Cardiology Associates P.A (843)-285-2500

I have read and understood the Medical Appointment Cancellation/No Show Policy and agree to its terms.

______________________________	______________________________
Signature(Parent/Legal Guardian)	(Relationship to Patient)
______________________________	______________________________
Printed Name	Date



Primary Care Physician: ____

Preferred Pharmacy Name and Address: _________________________________

Patient History

Check ALL of The Following That Apply To Your Medical History

Condition	✓
Anemia	
Aortic Aneurysm	
Abnormal Heart Rhythm	
Asthma	
Atrial Fibrillation/Flutter	
COPD	
Cancer	
Cardiomyopathy	
Carotid Disease	
Congenital Heart Disease/Cardiac Birth Defect	
Congestive Heart Failure (CHF)	
Coronary Artery Disease With or Without Cardiac Stents	
Coumadin Management	
Deep Vein Thrombosis (DVT)	
Diabetes	

Condition	✓
GERD/Reflux	
Heart Disease	
Hematologic Disease	
Hyperlipidemia	
Hypertension	
Kidney Disease	
Liver Disease	
Heart Attack	
Pacemaker	
Peripheral Artery Disease (PAD)	
Sleep Apnea	
Stroke/TIA	
Thyroid Disease	
Valvular Abnormalities/Murmur	

Cardiac History-Please CIRCLE any of the following that you have had in the past.

Electrocardiogram

Echocardiogram

Stress Test

Heart Monitoring

Heart Catheterization

Cardiac Stent

Cardiac Bypass Surgery

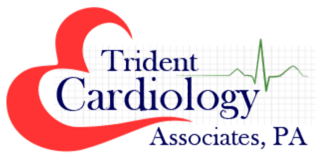
Heart Valve Surgery

Pacemaker/Defibrillator Placement

Cardiac Ablation or Cardioversion

Peripheral Stent or Vascular Surgery

Ankle/Brachial Index (ABI)



Surgical History-Please LIST any surgeries that you have undergone.___________________

____

____

Let Us Know About Any Cardiac Conditions or Risk Factors That Run In Your Family.

	Mother	Father	Brother(s)	Sister(s)	Other
AGE					
Alive or Deceased					
Medical Problems					

Have You Ever Smoked? Y or N Packs per Day?____ I Quit______Years Ago

Smokeless Tobacco (Please Circle One) Never Former Snuff User

E-Cigarrete/Vape (Please Circle One) Never Former Current

Chewing Tobacco (Please Circle One) Never 1-2 Day 2-4/Day 5+/Day

Caffeine Intake (Please Circle One) Never Occasional Moderate Heavy

Alcohol Intake (Please Circle One) Never Occasional Moderate Heave

Alcohol: Years Of Use_________________

Advanced Directive: Living Will: Y or N Power of Attorney: Y or N

Please List Any Illicit Drugs That You Use If Any:____________________________________

Medication Allergies-List Medication and Describe Reaction

____

____

Please Give Your Medication List To The Medical Assistant When You Are Called Back.