COMPLETE CARDIOVASCULAR CARE

Aron A. Barsky MD, FACC, RPVI

4 Ethel Road
Suite 405B
Edison, NJ 08817

732.287.0255 tel
732.287.0355 fax

njheartcare@gmail.com
www.njheartcare.com

Patient Information

Name: _____ Date of Birth: _____
(Last) (First) (M)

Address: _____ SS#: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Sex: _____ Marital Status: _____

Employer's Name: _____ Occupation: _____

Address: _____ Work Phone: _____

City: _____ State: _____ Zip Code: _____

Insurance

Name of Carrier: _____

ID#: _____ Group#: _____

Subscriber: _____ Relationship: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____
(Name & Relationship)

Referred by: _____ Phone: _____

Authorization for Payment and Release of Medical Records

Medicare:
I request that payments of authorized medicare benefits be made on my behalf to Dr. Aron A. Barsky for any services renendered by the physician. I authorize Dr. Aron A. Barsky to release medical information to HCPA and its agents any information needed to determine these benefits or the benefits payable for related services.

Other insurance:
I hereby authorize release of information necessary to file a claim with my insurance company and assignment of benefits otherwise payable to me to Dr. Aron A. Barsky. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Signature: _____ Date: _____

Advance Directive (Living Will): Yes☐ or No☐

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Medical/Family History

Please check all that apply to either you and your family:

Alcoholism	☐ You	☐ Family	High Blood Pressure	☐ You	☐ Family	Stroke	☐ You	☐ Family
Anemia	☐ You	☐ Family	Kidney Disease	☐ You	☐ Family	Suicide Attempt	☐ You	☐ Family
Asthma	☐ You	☐ Family	Liver Disease	☐ You	☐ Family	Thyroid Disease	☐ You	☐ Family
Cancer/Tumor	☐ You	☐ Family	Hepatitis	☐ You	☐ Family	Tuberculosis	☐ You	☐ Family
Diabetes	☐ You	☐ Family	Lung Disease	☐ You	☐ Family	Ulcer in GI tract	☐ You	☐ Family
Drug Abuse	☐ You	☐ Family	Mental Illness	☐ You	☐ Family	Venereal Disease	☐ You	☐ Family
Depression	☐ You	☐ Family	Osteoarthritis	☐ You	☐ Family	High Cholesterol	☐ You	☐ Family
Epilepsy/Seizures	☐ You	☐ Family	Osteoporosis	☐ You	☐ Family	HIV/Immune Dx	☐ You	☐ Family
Glaucoma	☐ You	☐ Family	Phlebitis	☐ You	☐ Family	Other_____	☐ You	☐ Family
Heart Disease	☐ You	☐ Family	Rheumatic Arthritis	☐ You	☐ Family			

Review of Systems

Please check Yes or No to all that apply to you:

Constitutional:

Weight Loss	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Fever	☐ Yes	☐ No

Eyes:

Glasses/Contacts	☐ Yes	☐ No
Eye Pain	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Cataract	☐ Yes	☐ No

Ear, Nose, Throat:

Difficulty Hearing	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No

Cardiovascular:

Murmur	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Difficulty Lying Flat	☐ Yes	☐ No
Swelling Ankles	☐ Yes	☐ No
Waking up Shortness of Breath	☐ Yes	☐ No

Skin:

Rash/Sores	☐ Yes	☐ No
Lesions	☐ Yes	☐ No
Itching/Burning	☐ Yes	☐ No

Respiratory:

Cough	☐ Yes	☐ No
Coughing Blood	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

Gastrointestinal:

Heartburn/Reflux	☐ Yes	☐ No
Nausea/ Vomiting	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No
Black or Bloody BM	☐ Yes	☐ No

Genitourinary:

Burning/Frequency	☐ Yes	☐ No
Nighttime	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
Erectile Dysfunction	☐ Yes	☐ No
Abnormal Discharge	☐ Yes	☐ No
Bladder Leakage	☐ Yes	☐ No

Allergic/Immunologic:

Hives/Eczema	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No

Endocrine:

Loss of Hair	☐ Yes	☐ No
Heat/Cold Intolerance	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No

Hematology/Lympy:

Easy Bruising	☐ Yes	☐ No
Gums Bleed Easily	☐ Yes	☐ No
Enlarged Glands	☐ Yes	☐ No
History of Clot	☐ Yes	☐ No

Musculoskeletal:

Joint Pain/Swelling	☐ Yes	☐ No
Stiffness	☐ Yes	☐ No
Muscle Pain	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No

Neurological:

Loss of Strength	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Memory Loss	☐ Yes	☐ No
History of Stroke	☐ Yes	☐ No

Psychiatric:

Anxiety/Depression	☐ Yes	☐ No
Mood Swings	☐ Yes	☐ No
Difficult Sleeping	☐ Yes	☐ No

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Current Medications

Date of Rx	**Medication name** *Brand or generic name*	**Dosage** *mg, units, puffs, drops*	**When do you take it?** *How many times per day? Morning & night? After meals?*	**Purpose and prescribing doctor**

Preferred Pharmacy:_____ Phone:_____

Allergies to Medications

Name of medication: Adverse reaction:

_____

_____

_____

Reason for Today's Visit

_____

_____

_____

Additional Information

Number of children _____

Tobacco use: Yes☐ No☐ Former☐ Date quit _____ How much? _____ How long? _____

Alcohol use: Yes☐ No☐ How many drinks per week? _____

Caffeine (coffee, tea, soda) per day? _____

Approximate date of last mammogram? _____ N/A _____

Approximate date of last blood work? _____

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Acknowledgment of Receipt of Notice

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES," revision date 04/14/03.

As required by the Privacy Regulations, Dr. Aron Barsky from this practice has explained the "Notice of Privacy Practices" to my satisfaction.

As required by the Privacy Regulations, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- ☐ I wish to file a "Request for Restriction" of my Protected Health information.
- ☐ I wish to file a "Request for Alternative Communications" of my Protected Health information.
- ☐ I wish to object to the following in the "Notice of Privacy Practices"

_____

_____

I understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original/previous version(s).

Signature: _____ Date: _____

Print Name: _____

(Official Use Only)

Signed from received by: _____ Date: _____

Signature

Good faith effort to obtain receipt. Describe: _____

_____

_____