



NEW PATIENT INFORMATION

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_

WITHIN THE LAST YEAR HAVE YOU HAD ANY OF THE FOLLOWING?

| TEST   | WHERE | PHONE# |
|--|-------|--------|
| _____ EKG                                    | _____ | _____  |
| _____ Thallium<br>(nuclear study)            | _____ | _____  |
| _____ Open Heart Surgery<br>(bypass)         | _____ | _____  |
| _____ Valve Surgery                          | _____ | _____  |
| _____ Cardiac Catherization<br>(angiography) | _____ | _____  |
| _____ PTCA<br>(balloon procedure)            | _____ | _____  |
| _____ ECHO<br>(sonogram of the heart)        | _____ | _____  |
| _____ Another Cardiologist                   | _____ | _____  |

WHO IS YOUR PRIMARY/FAMILY PHYSICIAN?

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

I authorize the release of my medical records to the Central Florida Cardiology Group for the dates listed above. This authorization includes consent to fax the above records to the office indicated below.

FAX/MAIL RECORDS TO: CENTRAL FLORIDA CARDIOLOGY GROUP, PA  
 1745 North Mills Avenue  
 Orlando, Florida 32803  
 Phone: (407) 841-7151  
 Fax: (407) 841-8572

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_