CENTRAL FLORIDA CARDIOLOGY GROUP, P.A.

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 (nuclear study)	_____	
_____	Open Heart Surgery (bypass)	_____	
_____	Valve Surgery	_____	
_____	Cardiac Catherization (angiography)	_____	
_____	PTCA (balloon procedure)	_____	
_____	ECHO (sonogram of the heart)	_____	
_____	Another Cardiologist	_____	

WHO IS YOUR PRIMARY/FAMILY PHYSICAN?

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, P.A.
1745 North Mills Avenue
Orlando, Florida 32803
Phone: (407) 841-7151
Fax: (407) 841-8572

_____

PATIENT SIGNATURE DATE

CFCG-8 11/10
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