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Aroor S. Rao, M.D., F.A.C.C
Rajendra Shetty, M.D., F.A.C.C
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Vikram Raya, M.D.,F.A.C.C
Claire DiPiero, PA-C

Personal Information

Name_____Date of Birth _____
Last First Middle
Address _____
Street City State Zip
Home Phone_____ Work Phone_____ Cell_____

Sex:_____ Marital Status:_____ SSN #: _____

Primary Care Physician: _____ Preferred Language:_____

Fax_____ SS# _____Sex_____Marital Status_____

Spouse's Name_____ Tel _____

Emergency Contact_____Tel_____Relationship_____

Email:_____ Race: _____Ethnicity: _____

Insurance & Pharmacy Information

Primary Insurance Name: _____
Name of Insured_____Relationship of Patient to Insured_____Copay_____
DOB of Insured_____ Member ID_____ Group ID_____

Secondary Insurance Name _____
Name of Insured_____Relationship of Patient to Insured_____Copay_____
DOB of Insured_____ Member ID_____ Group ID_____

Pharmacy Name_____Tel_____Fax_____
Address_____ Store No._____

Information and Assignment of Benefits

I authorize the release of medical information to my primary care physician, referring physician, or consults if needed and as necessary to process insurance claims, insurance authorizations and prescriptions. I also authorize payment of medical benefits to Capitol Cardiology Associates from my insurance company. I understand that payment is required for all services at the time they are rendered as well as co-payments and deductibles as due.
I certify that the information I have reported above is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature_____ Date_____

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Capitol Cardiology ASSOCIATES

Name_____ **DOB**_____ **Date**_____

Drug Allergies	**Current Medications**	**Hospitalization Or Surgery**	
		Date	Reason

Family History - Please list any health problems and causes of death if applicable

Father	
Mother	
Siblings	
Grandparents - Mother	
Grand Parents – Father	

Medical History (Yes / No)

Headache		Lactose Intolerance		Depression	
Shortness of Breath		Gallbladder Disease		Gout	
Heart Palpitations		Prostate Disease		Scarlet Fever	
Heart Murmur		Bowel Irregularity		Chronic Rashes	
Chest Pain		Incontinence		Rheumatic Fever	
Dizziness/Fainting		Sexual/Menstrual Dysfunction		Mumps	
Peripheral Vascular Disease		Venereal Disease		Measles	
Allergies/Hay Fever		Frequent Infections		Rubella	
Asthma		Hepatitis		Polio	
Bronchitis		Anemia		Diphtheria	
Pneumonia		Arthritis		Tetanus	
Ulcer		Osteoporosis		HIV/ADIS	
GI Disorder		Nervousness		Other	

Do You use recreational Drugs ? **Yes / No** Are you Sexually Active ? **Yes / No**

Social History

Smoke:	Packs Daily		Coffee:	Cups Daily		Sleep:	Difficulty falling asleep	
	How long?			Other Caffeine			Continuity disturbances	
	Interested to stop		Alcohol	Type			Snoring	

Women Only **P**regnant? **Yes / No** Planning Pregnancy? **Yes / No**

Patient Signature: _____

www.capitolcardiology.com
Main Office – Medical Office Building, 8116 Good Luck Road, Suite 305, Lanham, Maryland 20706
Phone 301-552-1200, Fax 301-552-1202
14999 Health Center Drive, Suite # 201, Bowie, Maryland 20716
Phone 301-552-1200, Fax 301-552-1202
Branch Avenue 7700 old Branch Avenue D203 Clinton Maryland 20735 1611
Phone 301-868-1220, Fax 301-856-3550

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Consent for Use and Disclosure Of Protected Health Information

We use information that you provide to us, including health information, to carry out treatment, payment, and health care operations. Please refer to our "Notice of Privacy Practices" for a more complete description. You have the right to review the notice before signing this consent.

The terms of our Notice of Privacy Practices may change. You may obtain a revised notice from our receptionist or by calling our office administrator for at (301) 552-1200.

You have the right to request that we restrict the use of your health information to carry out treatment, payment, or health care operations. We are not required to agree to the restriction. If we do agree to any restrictions, the agreement is binding on use.

You have the right to revoke this consent at any time by notifying us in writing. The revocation will not have any effect on any actions took in reliance on the consent prior to the time you revoke it.

I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment and health care operation purposes.

Patient Name (Print):_____

_____ _____

Signature of Patient or Patient's Representative Date