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**NEW PATIENT INFORMATION SHEET**

Date:

Patient’s Name:

 Last First Middle Initial

Date of Birth: Marital Status: \_\_\_\_\_\_

Address:

 Number & Street City State Zip

Phone Numbers: Daytime: Evening:

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:

Insurance:

Policy Number:

**Please Answer the Following Questions**

Are you presently taking any medication?

If yes, please list or provide a list

 Are you allergic to any medication?

 If yes, please list or provide a list

Are you currently under the care of a doctor for any reason?

 If yes, please explain

Have you been hospitalized in the past five years for more than two days?

 If yes, please explain

 Please circle any of the following you have (had):

 Anemia Cardiac Pacemaker Heart Trouble Rheumatic Fever

 Arthritis Convulsions Hepatitis Sinus Trouble

 Asthma Diabetes High Blood Pressure Stroke

 Any Blood Disease Epilepsy Jaundice Tuberculosis

 Bleeding Problems Glaucoma Kidney Problems Ulcers

 Cancer Heart Murmur Psychiatric Treatment X-Ray Treatment

 Other:

 \_\_\_\_\_\_

Patient’s Signature:

Signature of Responsible Party: