CARDIOVASCULAR CARE CENTER &CRC

CARE IS OUR MIDDLE NAME

1372 Wellbrook Circle NE, Conyers GA 30012
Phone: 470-500-CARE (2273) Fax: 470-289-5440

Today's Date_____

Reason for Visit: 1) Follow-up 2) Lab 3) Nuclear 4) Echo 5)New Symptoms

Last Name:_____ First Name:_____

Emergency Contact Name:_____Phone#;_____

Email Address: _____ (To Access to the Patient Portal)

Change in Home Address, Pharmacy and Insurance Yes No

If "Yes" ,Please provide new information:

Address:_____Phone #_____

Pharmacy:_____Phone #:_____

Insurance:_____Policy #:_____

If your insurance has changed, inform the receptionist. If we do not have the right information, you will become responsible for the bill. Please provide a copy of the new insurance card.

Currently, if you have any of the following symptoms, please circle them; otherwise, circle none:

Weight Gain
Weight Loss
Fever
Loss of Vision
Blurry Vision
Floaters
Diminished Vision
Hearing Loss
Cough
Chest Congestion
Nausea
Vomiting
Diarrhea
Constipation

Rash
Hives
Runny Nose
Sore Throat
Depression
Anxiety
Seizures
Headaches
Joint Stiffness
Joint Pain
Blood in Urine or Stool
Difficulty Urinating
Fatigue
Glucose Level Low or High

Patient Signature: _____ Date;_____