



JOHN A. OSBORNE, M.D., PH.D, F.A.C.C.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____ Date of Birth: _____
Social Security # _____ Provider Name: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to MedicalEdge Healthcare Group Inc. 's affiliated professional associations or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance for these services if they are not reimbursed by my insurance for whatever reason.

ACKNOWLEDGEMENT OF POTENTIAL FINANCIAL INTEREST IN ANCILLARY SERVICES:

I acknowledge that my physician may have a financial interest in the overall performance of ancillary services as part of his/her affiliation with a group practice. I understand that I should contact my treating physician if I have any questions regarding his/her potential financial interest in ancillary services.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge Healthcare Group PA. physician or his or her designee.

PATIENT SIGNATURE: _____

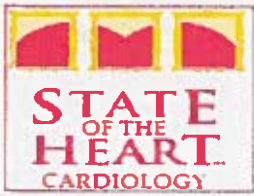
DATE: _____

GUARANTOR SIGNATURE: _____

DATE: _____

(If different from patient)

Guarantor Name (Please Print): _____



John A. Osborne, M.D., Ph.D., F.A.C.C.

NAME: _____ DOB: ____/____/____ SS# _____ Sex: Male Female

What is the name of the Dr. that referred you to us? _____ Name of your family Dr. _____

Why are you here to see a Cardiology (heart) doctor? _____

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

DOCTOR TO FILL OUT THIS SECTION

- Mark (X) on any HEART PROBLEMS or SYMPTOMS: Age _____
Heart attack, Angina, High Blood pressure, Blue lips or fingernails, Shortness of breath, Palpitations/Irregular heart beat, Leg cramps when you walk, Enlarged heart, Chest pain or pressure, Abnormal rhythm (arrhythmias), Dizziness, Swollen Legs, Heart Failure, Heart murmur, Fainting

- Mark (X) if you have ever had any of the following TESTS or PROCEDURES--Indicate approximate date test or procedure done:
Stress test, Coronary bypass surgery, Valve surgery, Electrocardiogram, Electrophysiology Study or Procedure, Cardiac Catheterization/ Heart catheterization, Pacemaker or Defibrillator, Coronary Angioplasty (balloon / atherectomy / stent)

- Mark (X) if you have:
High blood pressure, Diabetes, Overweight, High triglycerides, High Cholesterol: Total, LDL, HDL, T3, Ever smoked? Yes No, Quit (number of packs per day), Presently smoking (number of packs per day)

- Has a close family member had:
A Heart Attack? Yes No (Mother-Father- Sibling), Angina? Yes No, Bypass Surgery? Yes No, Surgery on their leg arteries? Yes No

For Women Only: Could you be pregnant? Yes No, Have you passed menopause (change of life)? Yes No, At what age? Do you take estrogen?

Are you being treated now or have you been treated for any illnesses?
1. _____ 3. _____
2. _____ 4. _____

Have you ever had any operations? Any injuries? (Please include date & year)
1. _____ 3. _____
2. _____ 4. _____

SOCIAL HISTORY:
What is your MARITAL STATUS?
Single (Never Married), Widowed, Separated, Married, Divorced
Spouse Name: _____ Number of children: _____

OCCUPATION: _____
MAJOR HOBBY: _____

HISTORY OF PRESENT ILLNESS:
Onset:
Frequency
Location
Quality
Severity
Timing
Duration
Associations
Aggravating
Alleviating
Cardiac Risk Factors?

Past Med HX / Past Surgery

Social HX / Family HX



NAME: _____

Date Seen: _____

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY	DOCTOR TO FILL OUT
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REVIEW OF BODY SYSTEMS: PLEASE MARK (X) YES or NO for each SYMPTOM

HEART	Yes	No		Yes	No		Yes	No
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diaphoresis	<input type="checkbox"/>	<input type="checkbox"/>	Othopnea	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/passing out	<input type="checkbox"/>	<input type="checkbox"/>	PND	<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR								
Claudication	<input type="checkbox"/>	<input type="checkbox"/>	Edema	<input type="checkbox"/>	<input type="checkbox"/>			
CONSTITUTIONAL								
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>						
Head, Ears, Nose, Throat								
Visual Changes	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Ringing	<input type="checkbox"/>	<input type="checkbox"/>
PULMONARY								
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL								
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
Abdominal Pain	Black or Tarry Stool							
GENITOURINARY								
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination at night	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>			
NEUROLOGICAL								
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>						
PSYCHOLOGICAL								
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>
HEMATOLOGIC								
Acute anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
REPRODUCTIVE								
Oral contraceptives	<input type="checkbox"/>	<input type="checkbox"/>						
ENDOCRINE								
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>			
DERMATOLOGICAL								
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Skin sores	<input type="checkbox"/>	<input type="checkbox"/>			
MUSCULSKELETAL								
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>			

PHYSICAL EXAM

BP:(L) _____

BP:(R) _____

Pulse: _____

Resp: _____

Weight: _____

PHYSICAL FINDINGS

CONST: _____

HEENT: _____

PULM: _____

THORAX: _____

CARDIAC: _____

ABD: _____

VASC: _____

EXT: _____

DERM: _____

M/S: _____

NEURO/PSYCH: _____

PROC SITE: _____

ASSESSMENT _____



NAME: _____ DOB _____

Date Seen: _____

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

DOCTOR TO FILL OUT

Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medications and herbal medicines.

MEDICATIONS:

1. ASPIRIN	YES / NO	81mg / 325mg	Enteric Coated	YES / NO
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Over the Counter Medications / Herbs

1		
2		
3		
4		

Allergies:
 Do you have any DRUG ALLERGIES ? Yes No (if yes, list them below)

ALLERGIES

Are you allergic to IODINE, SHRIMP OR SHELLFISH ? Yes No

Have you ever had a reaction to contrast dye ? (Mylegram, Kidney Series, CAT scan)
 Yes No

Have you had the following vaccinations ?

Influenza (FLU Shot) annually pneumococcal (Pneumonia) vaccine

Vaccinations



**STATE
OF THE
HEART**
CARDIOLOGY

John A. Osborne, M.D., Ph.D., F.A.C.C.
3801 William D. Tate
Suite 850
Grapevine, Texas 76051
817-310-3070

TODAY'S DATE: ____/____/____

RELEASE OF MEDICAL INFORMATION
(PLEASE PRINT)

Patient's Full Name: _____
(First / MI / Last)

Patient's Address: _____ City: _____ State: _____ Zip: _____

Home Telephone Number: () _____ - _____ Date of Birth ____/____/____ Social Security No _____ - _____ - _____

I hereby request that my complete medical records be released to Dr. John A. Osborne for his use in my medical care. This consent is only for the release of medical records and should include all medical notes, lab studies, surgical reports, x-ray reports, EKG's and other diagnostic reports. Please expedite my request and mail my medical records to -

Name of Recipient: John A. Osborne, M.D.

Address: 3801 William D. Tate; Suite 850

City & State: Grapevine, Texas Zip Code: 76051

Signature of patient or authorized representative Date: _____

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Unless otherwise revoked, this Authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. If I have any questions about disclosure of my health information, I can contact Cherrie Crawley at 972-739-3070.



JOHN A. OSBORNE, M.D., PH.D, F.A.C.C.

CONFIDENTIAL - PROTECT PATIENT PRIVACY

Patient Registration Form

Office Location: 3801 William D. Tate Ste. 850 Grapevine Texas 76051

Tel: (817)-310-3070

Fax: 817-310-0023

TODAYS DATE: / /

RECORD NUMBER:

PATIENT INFORMATION: (Full Legal Name, No Nicknames) (Mr.) (Mrs.) (Ms.) (Dr.) Last Name: First Name: Middle Initial: Who referred you to our practice?: How would you like to be addressed by your physician? Address: City: State: Zip Code Home Phone: Mobile/Pager: Social Security # Date of Birth: Age: Sex: Drivers License # Marital Status: (Married) (Divorced) (Single) (Widowed) Employer Name: Address: Work Phone: E-mail Address: Emergency Contact Name: Relationship: Emergency Number: Pharmacy Name Phone #

GUARANTOR INFORMATION: (List person responsible for bill - use full legal name, no nicknames) Relationship to Guarantor: (SELF) (SPOUSE) (PARENT) (OTHER) If self, and contact information is same as above check here: Last Name: First Name: Middle Initial: Address: City: State: Zip Code: Date of Birth: Home Phone: Work Phone: Employer Name: Address:

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards and Drivers License) Primary Insurance Plan Name: Insured's Name: Insured's Social Security # Insured's Date of Birth: Policy / ID# Group # Effective Date: Claims Address: Phone: Secondary Insurance Plan Name: Insured's Name: Insured's Social Security # Insured's Date of Birth: Policy / ID# Group # Effective Date: Claims Address: Phone: Oct-10



JOHN A. OSBORNE, M.D., PH.D, F.A.C.C.

3801 William D. Tate
Suite 850
Grapevine Texas 76051
Phone: 817-310-3070
Fax: 817-310-0023

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

This practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the "Notice of Privacy Practices"

Name of Patient (Print)

Signature of Patient

Date of Signature

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regular answer your calls? **Yes** **No** **N/A**

May we leave messages on a voice mail at work? **Yes** **No** **N/A**

May we discuss your appointments/treatment with your spouse? **Yes** **No** **N/A**

If you are over the age of 18, still living at home, may we discuss your appointments/treatment with your parent(s) or guardian? **Yes** **No** **N/A**

If you are over the age of 18, may we discuss your appointments and/or treatment with your children? **Yes** **No** **N/A**

You must inform us in writing if you wish to change the manner in which this office communicates to you.

Please place in the patient's medical record.



JOHN A. OSBORNE, M.D., PH.D, F.A.C.C.

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CONSENT TO TREATMENT:

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DATE: _____

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