500 E. Robinson Street Suite 900
Norman, OK 73071
P: (405) 321-0199 / F: (405) 321-8305

Heart Clinic
of Central Oklahoma, P.C.

M. Anwar, M.D.
Ahmad B. Sarwar, M.D.
Areebah Anwar, PA-C

NEW PATIENT REGISTRATION

Date _____

Patient Information – Please Print

NAME (Last, First, Middle)	SSN#	DOB	SEX
HOME ADDRESS (City, State, Zip)			
CELL PHONE	SECONDARY PHONE	EMAIL	
EMERGENCY CONTACT NAME	TELEPHONE NUMBER	RELATIONSHIP TO PATIENT	

Primary Insurance

NAME OF INSURANCE COMPANY	POLICY #	
NAME OF INSURED	GROUP #	
ADDRESS OF INSURANCE COMPANY	SPECIALIST CO-PAY AMOUNT ($)	
CITY, STATE, ZIP	DEDUCTIBLE AMOUNT ($)	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRE DATE

Secondary Insurance (If Applicable)

NAME OF INSURANCE COMPANY	POLICY #	
NAME OF INSURED	GROUP #	
ADDRESS OF INSURANCE COMPANY	CO-PAY AMOUNT ($)	
CITY, STATE, ZIP	DEDUCTIBLE AMOUNT ($)	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRE DATE

Primary Care Provider Information

NAME OF COMPANY	PROVIDER NAME
ADDRESS (City, State, Zip)	
PHONE	FAX

Referring Provider Information

NAME OF COMPANY	PROVIDER NAME
ADDRESS (City, State, Zip)	
PHONE	FAX

HISTORY AND PHYSICAL

REASON FOR MEDICAL TREATMENT:

DRUG ALLERGIES:

CURRENT MEDICATIONS (including prescription, over the counter, vitamins, herbs. etc.):

DATE OF LAST DOCTOR VIST | NAME OF DOCTOR | REASON FOR VISIT

PHARMACY NAME: | LOCATION/ADDRESS:

Past Medical History/Review of Symptoms

(Please check if you have had problems or been diagnosed with any of the following)

_____Abdominal Discomfort
_____ Alcohol Abuse
_____ Anemia
_____Anxiety
_____Arthritis
_____Arrhythmias
_____Asthma
_____Blood in Stool
_____Bronchitis
_____Cancer
_____Cardiomyopathy
_____Chest pain/Discomfort
_____Congestive Heart Failure
_____Constipation
_____Depression
_____Diabetes
_____Difficulty Hearing
_____Difficulty Seeing
___Difficulty w/ Movement
___Dizziness
___Drug Abuse
___Frequent Urination
___Gout
___Headache
___Heart Disease
___Hepatitis/Jaundice
___High Blood Pressure
___High Cholesterol
___Indigestion/Heartburn
___Kidney Disease
___Lightheadedness
___Low Back Pain
___Muscle Pain
___Nausea
___Palpitations/Racing Heart
___Pneumonia
_____Rheumatic Fever
_____Shortness of breath
_____Stroke
_____Swollen Ankles
_____Swollen Feet
_____Thyroid Disease
_____Tuberculosis
_____Ulcer
_____Unexplained Weight Change
_____Venereal Disease
_____Vomiting
_____Other: _____

Hospitalization or Surgery

(Please list any surgery or hospitalization(s) which you have had and include the dates)

Family History

(Please check and describe if any member of your family including parents, siblings, and grandparents ever had the

_____Abdominal Heart Rhythm _____
_____Bleeding Disorder _____
_____Cancer _____
_____Cardiomyopathy _____
_____Congestive Heart Failure _____
_____Diabetes _____
_____Heart Disease _____
_____High Blood Pressure _____
_____Kidney Disease _____
_____Premature (Early) Heart Attack _____
_____Stroke _____
_____Sudden Cardiac Death _____

Social History
(Check all that apply)

☐	ALCOHOL: Type:	Amount:	
☐	COFFEE: Cups Daily:	Other Caffeine:	
☐	CONTACT WITH BLOOD/BODILY FLUID AT WORK:		
☐	DIET: Salt Intake:	Fat Intake:	Other:
☐	EXERCISE ROUTINE:		
☐	SLEEP PROBLEMS:		
☐	SMOKE: Packs Daily:	How Long:	Interested in Stopping:

How Did You Hear About Us?_____

Insurance coverage is a method of reimbursement to the patient for services rendered by the physician and is not a substitute for payment. Insurance companies may provide fixed allowances for certain procedures or may reimburse a percentage of the billed charges. You are responsible for any deductible, coinsurance, copayment, or remaining balance not covered by your insurance plan. It is also your responsibility to obtain any required preauthorization prior to receiving services. If services are rendered without the necessary authorization, the full cost of the visit will be your responsibility. To avoid unexpected charges, please ensure all required authorizations are in place before your appointment. In the event that this account is referred to an attorney or collection agency for collection or legal action, the practice shall be entitled to recover reasonable attorney's fees, collection costs, and related expenses.

I authorize the release of any information necessary to determine liability for payment and to process and obtain reimbursement for my insurance claims. I further request and authorize that payment of any authorized benefits be made directly to the practice on my behalf. I assign to the practice all benefits payable under Medicare, private insurance, and any other health plans. This assignment remains in effect until revoked by me in writing. A photocopy of this authorization shall be considered as valid as the original.

I understand that I am financially responsible for all charges incurred, regardless of insurance coverage or payment determination. I understand and agree that if my account is referred to a collections agency, a fee of up to 30% may be added to the outstanding balance.
I agree to the assignments and financial responsibilities shown on this form.
I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Signature:_____ **Date:** _____/_____/_____

I hereby authorize Dr._____ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Doctor (or to the party who accepts assignment).
I certify that the information I have reported with regard to my insurance coverage 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:** _____/_____/_____
(Patient, Parent or Guardian)