MONTGOMERY CARDIOVASCULAR ASSOCIATES, P.C.

H Forrest Flemming, MD
Paul B Moore, MD
Wynne Crawford, MD
R Eric Crum, MD

Amy B Cooper, MD
Scott W Sims, MD
Ashwini Sharma, MD
John O. Kolawole, MD

New Patient Registration Information

Last Name:	First Name:	Middle Initial:
Gender:	Date of Birth:	Primary Care Provider Full Name:
Mailing Address:	City/State:	Zip Code:
Home Phone #:	Cell Phone #:	Previous Cardiologist Name and contact information:
Do you have a preferred cardiologist here you would like to see? If so, please indicate: Dr Flemming ___ Dr Moore ___ Dr Crawford ___ Dr Crum ___ Dr Cooper ___ Dr Sims ___ Dr Sharma ___ Dr Kolawole ___ Dr Wool ___	Emergency Contact: Name: Relationship: Phone #:	If previously cared for by Southeastern Cardiology Consultants prior to their abrupt closure, when were you due to be seen again? Month _____ Year_____
Do you have an implanted cardiac device? If so, what kind: Pacemaker: ___ Defibrillator: ___ Implanted Loop Monitor: ____ What brand: _____	Your email address:	
Primary Insurance Plan Name:	Policy Holder Name: Relationship: self __ spouse__other__ Gender: Male ___ Female: ____	Member ID:
Secondary Insurance Plan Name:	Policy Holder Name: Relationship: self __ spouse__ other__ Gender: Male ____ Female: ____	Member ID:

Please complete this form and a medical record release. You may deliver to any of our office locations, mail to P.O. Box 241587 Montgomery AL 36124 email to mr@mcva.com or fax to 334-280-1600

Please make certain that we are an in-network provider with your insurance plan

If you need prescription refills for your cardiac medications prior to your appointment, please contact your previous cardiologist office or your primary care physician.

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Mailing Address: PO Box 241587 Montgomery, AL 36124
Phone: (334) 280-1500 Fax: (334) 280-1600
Website: www.mcva.com

MEDICAL RECORD REQUEST

Patient Name: _____DOB: _____

(Physician or Facility) _____

FAX: _____ **Phone:** _____

Treatment Dates requested: _____	___ Echo Report
___ Discharge Summary	___ EKG/Stress Strips
___ History & Physical	___ Holter/Event Monitor
___ Operative Rpt	___ Lab Work
___ ER Record	___ Physician's Progress Notes
___ Stress Test Rpt	___ Physician's Orders
___ Chest X-Ray	___ Other:_____

FAX REQUESTED RECORDS TO 334-280-1600 ATTN: _____ (person completing form)

RELEASE OF INFORMATION

Please release the information checked below from Montgomery Cardiovascular Associates to:
_____ Address:_____ Fax#:_____

Phone#_____

Treatment Dates requested: _____	___ Echo Report
___ Discharge Summary	___ EKG/Stress Strips
___ History & Physical	___ Holter/Event Monitor
___ Operative Rpt	___ Lab Work
___ ER Record	___ Physician's Progress Notes
___ Stress Test Rpt	___ Physician's Orders
___ Chest X-Ray	___ Other:_____

Information about you is protected under federal law and you have the right to revoke this Authorization except to the extent that we have taken action in reliance on your Authorization. Please contact the MCA Medical Records Department for an "Authorization Revocation" form if one is needed. By signing below, you recognize that the protected health information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Expiration: Unless otherwise, revoked, this authorization will expire on the following date, event, or condition: If I do not specify an expiration date, event, or condition, this authorization will not expire. Date:_____/____/_____

Patient's Signature:_____Date: _____

As a Personal Representative, I have authority to act for the individual because I am:
_____

MCA Witness:_____Date: _____

MCA Account#_____