Corvita Health & Associates Patient information

Name: ______________________________ Date of birth: ______________

Sex: circle one Male Female **Social Security Number:** ______________

Address: ____

City: ______________ **State:** ________ **Zip code:** ______________

Mobile phone: ______________ **Home phone:** ______________

Email: ______________________________ **Preferred method of communication: circle one**

Mobile Home Email

Emergency contact: ______________ Phone: ______________ Relation: ______________

Ethnicity: circle one: (optional) • Hispanic or Latino • Not Hispanic or Latino

Race: circle one (optional)

• White • Black or African American • American Indian or Alaska Native • Asian • Native Hawaiian or Other Pacific Islander

Referring cardiologist: ______________ **Primary Care physician:** ______________

History of Smoking? ________ **If quit, date?** ______________

Family History: Any family members die young or suddenly? ______________

If yes, please explain: ______________________________

Current list of medications with dosages: ______________________________

____

Medication Allergies: ______________________________

Pharmacy information: ______________________________