New York Cardiology Associates P.C.

HOLLY S. ANDERSEN, M.D.
ROBERT D. CAMPAGNA, M.D.
FREDERICK J. FEUERBACH, M.D.
HARVEY L. GOLDBERG, M.D.
KIRSTEN O. HEALY, M.D.
LAWRENCE A. KATZ, M.D.
MARTIN R. POST, M.D.
ALLISON SPATZ, M.D.

Date:_____

Patient Name:_____ **Date of Birth:**_____

Our office has started Electronic Prescribing. We request that you list the pharmacy of your choice below. If you use a chain pharmacy, such as Duane Reade or CVS, please include the store number as well as the address and/or phone number. If you use a mail order pharmacy, please indicate which one below.

Pharmacy Name:_____ **Store Number:**_____

Address:_____

Phone Number:_____

Mail Order Pharmacy (Please check only one)

[ ] Medco	[ ] Express Scripts	[ ] CVS/ Caremark Mail Order
[ ] RightSource Rx	[ ] Prescription Solutions	[ ] CVS/Caremark Specialty
[ ] Cigna Home Delivery	[ ] Costco Mail Order	[ ] Aetna Rx Home Delivery

[ ] OTHER: _____

As a component of Electronic Health Record, the government has determined that the following demographics should be included in your patient profile.

Language (Please check only one)

[ ] English	[ ] German	[ ] French	[ ] Vietnamese
[ ] Italian	[ ] Mandarin	[ ] Spanish	[ ] Arabic

Race (Please check only one)

[ ] Asian	[ ] Caucasian	[ ] Black or African American
[ ] American Indian	[ ] Alaska Native	[ ] Chinese
[ ] Filipino	[ ] Japanese	[ ] Native Hawaiian
[ ] Multiracial	[ ] Pacific Islander	
[ ] Undetermined	[ ] Other	

Ethnicity (Please check only one)

[ ] Hispanic or Latino	[ ] Non-Hispanic or Latino	[ ] Other / Undetermined

THE FOLLOWING SECTION IS OPTIONAL:

As a component of Electronic Prescribing, we need your consent to access your medication history from your pharmacies. Please sign your name below if you give your consent.

I give my consent for New York Cardiology Associates to access my medication history via Electronic Prescribing.

Signature:_____