FLORIDA HEART CENTER, P.A.

Practice Limited to Cardiovascular Disease

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WELCOME TO OUR OFFICE - PATIENT INFORMATION

In order to serve you properly, we need the following information. All information is strictly confidential.

PLEASE PRINT CLEARLY

Date: _____

Referring Physician: _____

PATIENT NAME: _____ Sex: M ___ F ___
Last First MI

SSN # _____ MARITAL STATUS _____ BIRTHDAY _____

ADDRESS: _____ CITY: _____ ST: ____ ZIP CODE: _____

MAILING ADDRESS: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ ADDRESS: _____ PHONE: _____

SSN of Spouse (Parent/Guardian) _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

Chief complaint/reason for visit: _____

Date of last general physician examination: _____ Do you have hypertension? _____

Describe any conditions we should know about: _____

PRIMARY INSURANCE COMPANY: _____ POLICY #: _____

INSURED NAME: _____ INSURED SSN #: _____

INSURED DOB: _____ GROUP #: _____

SECONDARY INSURANCE: _____ COMPANY: _____

Please give cards to receptionist for copying

I understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of insurance benefits.

Signature: _____ Date: _____

I hereby authorize my insurance benefits to be paid directly to the above-signed physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Cardiology Consultations, Echo, Stress Test, Nuclear Cardiology, Holters, Pace Makers, Cardiac Catherization, Peripheral Angiography, Coronary and Peripheral Interventions, CT Angiography

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Medical Records Release

--Authorization for Use or Disclosure of Protected Health Information—

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period
This authorization for release of information covers the period of healthcare from:
a. □ _____ to _____.

OR
b. □ all past, present, and future periods.

3. Extent of Authorization
a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR
b. □ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of patient or personal representative Date

_____
Printed name of patient or personal representative and his or her relationship to patient

(All information is strictly confidential)

FAMILY HISTORY: Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check ( ) if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart disease, Strokes	
Sisters					High blood pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITILIZATIONS

Year	Hospital	Reason for hospitalization and Outcome

SURGERY: List all operations

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Birth year	Sex	Complications, if any

HEALTH HABITS: Check ( ) substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS: Check ( ) if your work exposes you to the following:

	Stress
	Hazardous substances
	Heavy lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Signature Date

HEALTH HISTORY

(Confidential)

Name: _____ Today's Date: _____

Age: ____ Birth date: _____ Date of last physical examination: _____

What is your reason for visit? _____

SYMPTOMS: Check ( ) symptoms you currently have or have had in the past year.

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Dizziness/Lightheadedness

RISK FACTORS:
CORONARY ARTERY DISEASE
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Smoking
- ☐ High cholesterol
- ☐ Family history of Coronary artery disease
- ☐ Peripheral Vascular Disease

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss if sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

MUSCLE/JOINT/BONE
- ☐ Arms
- ☐ Back
- ☐ Feel
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

GENTIO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

WOMEN only
Date of last menstrual period: ____ _____

CONDITIONS: Check ( ) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataract
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

MEDICATIONS: List medications you are currently taking	**ALLERGIES:** To medications or substances

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Acknowledgement of Privacy Practice Notice

The Florida Heart Center, P.A. will make every attempt to ensure the confidentiality of your Protected Health Information (PHI) as set forth by Hippa.

You have the right to be notified of our privacy policies. Notice is posted in the main lobby area of our waiting room. You also have the right to receive a written copy of the privacy practices of the Florida Heart Center, P.A.

I have read and understand the above notice. I understand I have the right to request a written privacy policy from the Florida Heart Center, P.A.

I authorize the release of my medical information and/or medical records to the following person/ persons only:

Name_____ Phone_____

Name_____ Phone_____

Name_____ Phone_____

_____ _____

Patient Signature Date

_____ _____

Witness Date

Florida Heart Center, P.A.

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

The Florida Heart Center is required by law to maintain the privacy of Protected Health Information (PHI). This notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. Protected Health Information includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the healthcare you received or payment for your health care. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice.

PERMITTED USES AND DISCLOSURES

Florida Heart Center is permitted to use or disclose your PHI for purposes of payment , treatment and health care operations

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering xrays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, and insurance company or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

We may use and disclose health information about in order to run the office and make sure that you and our other patients receive quality care. An example is we may use your health information to help us decide what additional services

we should offer, how we can become more effective, or whether certain new treatments are effective.

We may contact you as a reminder that you have an appointment or treatment or medical care at our office.

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so. We may also disclose your health information to friends if we can infer from the circumstances, based on our professional judgement that you would not object.

PATIENT RIGHTS

You have the right to inspect and copy your health information, such as medical and billing records that we use to make decisions about your care. You must submit a written request to our office in order to inspect and /or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing and other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed.

If you believe your information we have is incorrect, you may ask us to amend the information. Your request to amend must be writing. We may deny your request if: We did not create the error. If not part of the health information that we keep. If the information is accurate and complete.

You have the right to request an accounting of disclosures. This request must be submitted in writing to our office. This disclosure will be from the effective compliance date of 4-14-03. We have the right to charge for the costs of providing this list. You will be notified of any such cost involved..

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must complete a form for restricting uses and disclosures and confidential communcations.