Plano Heart Center, P.A.

Date: ________________

How did you hear about us: ☐ Physician Referral ☐ Advertisement ☐ Friend ☐ Other. Please specify: ____________________

Patient Information

Name: ____ Social Security #: __________________

Address: ______________________________________ City: __________________ State: ___ Zip: ________

Home Ph: ___________________ Business Ph: _________________ Cell Ph: _________________

Date of Birth: ____________ Age: ______ ☐Male ☐Female ☐Married ☐Single ☐Widow ☐Divorced

Employer Name: ______________________ Employer Address: ____

☐Full time ☐Part time ☐Retired ☐Self employed ☐Student fulltime ☐Student part time

Referring Physician: _____________________________ Referring Physician Ph: ________________________

Primary Care Physician: __________________________ Primary Care Physician Ph:______________________

Insured Name (If no insurance, responsible party)

Name: ____ Relationship: ______________________

Social Security #: ____________________ Date of Birth: ______________________

Address: ______________________________________ City: __________________ State: ___ Zip: ________

Home Ph: ___________________ Business Ph: _________________ Cell Ph: _________________

Employer name: ______________________ Employer address: ____

Notify In Case of Emergency

Name: ____________________ Relationship: ____________ Home Ph: ____________ Business Ph: _____________

Name: ____________________ Relationship: ____________ Home Ph: ____________ Business Ph: _____________

Insurance Information

Insurance 1: ____

Address: ____ Phone: ____________________

Social Security #: ____________________ Policy #: __________________ Group # ___________________

Insurance 2: ____

Address: ____ Phone: ____________________

Social Security #: ____________________ Policy #: __________________ Group # ___________________

Authorizations

For and in consideration of the services rendered by Plano Heart Center P.A., I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health insurance deductible and coinsurance charges not covered by my insurance policy and charges not covered as a result of any law settlement or judgments obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my insurance policy, to include, charges for services deemed experimental, investigational and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and assign Plano Heart Center P.A. all rights, title, and interest in any payment due me for services described herein as provided in the above mentioned policies of insurance/settlements or judgments. I hereby consent to the release of information necessary to process claims with my insurance policy. I understand that the specific information to be released may include, but is not limited to, history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases including HIV and AIDS. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the receipt of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Signed ____ Date: ___________________

Patient Name (Please Print): ____

Witness Signature: ____ Date: ___________________

INITIAL VISIT

Patient Name: ____________________________ Consult request from: _________________________
DOB: ________________ Date: ___________ Referral recv'd from: _________________________

Please help us find out about you by filling out the "Patient" side of this form. Please leave the "Physician" side blank.

PATIENT	PHYSICIAN
Why are you here to see a cardiologist? ____	**CC**
Check off any heart problems or symptoms ☐ Heart Attack ☐ Angina ☐ High Blood Pressure ☐ Heart Murmur ☐ Rheumatic Fever ☐ Abnormal Rhythm (arrhythmia) ☐ Palpitations, irregular heartbeats ☐ Fainting ☐ Enlarged heart ☐ Chest pain or pressure ☐ Shortness of breath ☐ Dizziness ☐ Swollen legs ☐ Blue lips or fingernails ☐ Leg cramps when you walk	**HPI** Elements: Location, quality, severity, duration, timing, context, modifying, factors, associated signs and symptoms.
Have you ever had: ☐ A Stress Test ☐ An Echocardiogram (Ultrasound or Sonogram) ☐ Cardiac Catheterization/Heart Catheterization ☐ Coronary Angioplasty (balloon) ☐ Coronary Bypass Surgery ☐ Valve Surgery ☐ An Electrophysiology Study or Procedure ☐ A Pacemaker or Defibrillator	
Tell us about your risk of heart disease. Please check if you have: ☐ High blood pressure ☐ High cholesterol ☐ Ever smoked ☐ Diabetes	
Do you exercise (including walking)? ____	
Has a close family member had a heart attack, angina, or bypass surgery? ______________________________ Who? ______________________________	
If you are a woman, have you passed menopause (change of life)? ______________________________ At what age? ______________________________ Do you take estrogen replacement? ____________________ Please tell us anything else about your heart: ____ ____	

Patient	Physician
Please tell us about your medicines (names, dose or strength , how many time a day). Include over-the-counter medications: 1. ____ 2. ____ 3. ____ 4. ____ 5. ____ Please circle any symptoms you have, so we can find out more about it.	**Medicines**
Lack of energy, weakness, fatigue, trouble sleeping, loss of appetite, weight change, fever	Constitutional
Double or blurred vision, pain, redness, glaucoma, cataracts	EYES
Ear: buzzing or ringing in ears, discharge, use of hearing aid Nose: frequent colds, discharge, nose bleed Mouth: dry mouth, bleeding gums, wear dentures Throat: hoarseness, sore throats	ENMT
High BP, murmur, chest pain/discomfor, palpitations, shortness of breath, breathing discomfort when lying down, abnormal EKG or other heart tests, rheumatic fever, swelling in legs, past vein clots, leg pain/weakness	Cardiovascular
Wheezing, cough, coughing blood, bronchitis, asthma, emphysema, TB, pneumonia	Respiratory
Trouble swallowing, heartburn, indigestion, regurgitation, nausea, vomiting, abdominal pain, ulcers, change in bowel habits, constipation, bloody or dark stools, hemorrhoids, liver problems, jaundice, gallstones	Gastrointestinal
Urination frequency, pain, incontinence, stones, burning, blood in urine. Men: discharge, sores, pain, mass, hernia. Women: breast lumps, abnormal mammogram, abnormal pap-smear, irregular/abnormal periods, menopause or menopausal symptoms.	Genitourinary
Joint pain, swelling, stiffness, muscle pain, tenderness, weakness, limitation on movement, gout, arthritis, back pain.	Musculoskeletal
Rash, itching, sores, lumps, dryness, changes in hair or nails, change in skin color	Skin
Paralysis (even temporary), stroke, numbness, loss of balance, fainting, blackouts, weakness, loss of sensation, seizures, headaches.	Neurologic
Unusual thoughts, nervousness, crying or sadness, tension, loss of memory, depression, suicide thoughts	Psychiatric
Thyroid disorders, diabetes, excessive thirst or hunger, excessive urination, excessive sweating	Endocrine
Bleeding, easy bruising, anemia, cancer, transfusion, risk factors of HIV	Hematologic
Allergic to medications, allergies to other substance, immune suppressed	Allergy/Immunologic

PATIENT	PHYSICIAN
Are you being treated now or have you been treated for any illness? Please list: ______________________________ ______________________________ ______________________________ ______________________________ ______________________________	**PFSH** Past Med Hx
Have you had any injuries? Any surgeries? ______________________________ ______________________________ ______________________________ ______________________________ ______________________________	Past Surg Hx
Marital Status: S M W D Your Occupation: ______________________________ With whom do you live? ______________________________ Pleasure Activities: ______________________________ ______________________________ ______________________________ Education Level: ______________________________ Health Habits: Do you smoke? ______________________________ If yes, how many packs per day? ______________ For how many years? ______________________ How much alcohol do you drink? ______________ Do you use any illegal drugs? ______________________	Social History
Do any close family members (parents, brothers, sisters, children) have any of the following: Heart problem High blood pressure Diabetes Cancer Are there any health problems in your family? ______________________________	Family History
Are you allergic to any medications? ______________________________ What kind of reaction did you have? ______________________________	Allergies

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed under federal and state law, and outlining my rights regarding my health information.

Patient Name: ___________________________ Date: ______________

Signature: ______________________________
Patient or authorized legal representative

Authorization for Disclosure of Protected Health Information

I authorize Plano Heart Center, P.A. to disclose or discuss my protected health information with the following entities or family members:

	Name	Relationship
1.		
2.		
3.		
4.		
5.		

The information to be disclosed may include history & physical, lab work, operative/hospitalization reports, and diagnostic tests. This authorization is effective until I specifically revoke it.

I have the right to revoke this authorization in writing at any time by notifying Plano Heart Center, P.A. A revocation does not pertain to information used or disclosed prior to the time of revocation. I understand that my protected health information used or disclosed pursuant to this authorization may be redisclosed by the entity receiving it.

Patient Name: ___________________________ Date: ______________

Signature: ______________________________
Patient or authorized legal representative

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy to collect this copayment when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have prior agreement, we may require payment for charges for your care and treatment at the time of the service.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. Please check with your insurance company as to services covered.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Lab/Blood Work Orders

- We refer patients to either Lab Corp or Quest Diagnostics for any blood work ordered by the physician. In most cases, the lab will bill your insurance unless you make other payment arrangements. In the event that your health plan determines a lab order to be "not covered," you will be responsible for the complete charge. Please check with the lab or your insurance company as to lab services covered prior to getting them done. We do not have any financial arrangements with any lab and are in no way responsible for any lab charges.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I understand it is my responsibility to verify services covered with my insurance company. I also understand and agree that the practice may amend such terms from time to time.

____

Printed Name of the Patient

____ ____________________

Signature of Patient or Responsible Party if a Minor Date