

**CENTRAL FLORIDA HEART ASSOCIATES, PA**

**932 Saxon Blvd, Suite A 750 West Plymouth Avenue 1403 Medical Plaza Drive**

**Orange City, Florida DeLand, Florida 32720 Suite 106**

**Phone: 386-774-2100 (Dr. Edwards’ Office) Sanford, Florida 32771**

**Fax: 386-774-0326 (407) 330-9900**

 **RAJENDRA HIPPALGAONKAR, MD, FACC ROBERT ROSEMOND, MD**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Patient,

Thank you for choosing Central Florida Heart Associates. We welcome you to our practice. Enclosed you will find paperwork that must be completed before your appointment. **Please** take the time to fill it out **completely, front and back**. This will save time on the day of your appointment.

Please be sure to **bring them all** with you, as well as your **insurance card(s)** and a form of **photo identification**, i.e., employee ID, driver’s license, or even a small passport photo. If you forget these items, we will not be able to see you until they are completed; so please remember them all.

Please feel free to bring a book to read while you wait. Sometimes, due to the nature of cardiology, there may be an emergency, which delays the physician. We do not like to have this happen, but want you to be aware that it could. Our doctors will give you the same care and courtesy if you are ever the emergency case. We hope you will understand the delay if it should occur.

**Please** bring a list of **all medications** you are currently taking, as well as the dosage and frequency. There is a “**Release of Medical Records”** form included in this packet. Please fill it out, **sign,** and return it to our office so that we are able to obtain records, which are pertinent to your current cardiac status. Having this information will help us to better know the correct choices for your personal treatment.

**Thank you** again for your cooperation. **We look forward to seeing you soon.**  Your appointment is scheduled for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ a.m./p.m.

Sincerely,

*Your friendly office staff*

**Central Florida Heart Associates, PA**

**New Patient Information**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **First Middle Last**

**Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_\_\_\_\_\_\_\_\_ Female \_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT INFORMATION**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

**Primary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy/ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy/ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a living will? Yes \_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_**

**I certify that the above information is true to the best of my knowledge. I understand that any co-pays are due at the time of my visit, and any deductibles or co-insurances not covered by my insurance company are my responsibility.**

**Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Central Florida Heart Associates, PA**

|  |  |  |
| --- | --- | --- |
| 1403 Medical Plaza Dr., Ste 106Central Florida Heart Associates, PASanford, FL 32771 | 932 Saxon Blvd., Ste. AOrange City, FL 32763 | 750 W. Plymouth Ave.DeLand, FL 32720 |
| Phone: 386-774-2100 Fax: 386-774-0326 |

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

**I hereby authorize use or disclosure of the named individual’s health information as described below:**

**\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name Date of Birth Social Security**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Address (street, city, state, zip code)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Phone Number**

**The following individual or organization is authorized to make the disclosure:**

* **Central Florida Heart Associates, PA**
* **Other, (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This information may be disclosed to and used by the following individuals or organizations:**

* **Central Florida Heart Associates, PA**
* **Other family member, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treatment Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **“ALL” for all treatment dates**

**Purpose of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The following information is to be disclosed: (check all that apply)**

|  |  |
| --- | --- |
| * **Physician Notes**
 | * **Cardiac Studies**
 |
| * **Lab Results**
 | * **Medication History**
 |
| * **X-ray Reports**
 | * **Complete Record**
 |

**Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SENSITIVE INFORMATION: I hereby authorize the use or disclosure of my individual identifiable health information which may include information regarding drug abuse, HIV/AIDS diagnosis, alcohol abuse, and/or psychiatric/psychological treatments. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal policy regulations.**

**RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that the revocation will not apply to information already releases based on this authorization.**

**EXPIRATION: Unless otherwise revoked, this authorization will expire one year from the date of signature or on a date, event, or condition specified by the patient or legal representative.**

**\*Signature of Patient or Legal Representative \*Date**

**\*Relationship to Patient**

**Central Florida Heart Associates, PA**

**932 Saxon Boulevard, Suite A**

**Orange City, Florida 32763**

**(386) 774-2100**

**Yearly Signature Agreement**

**Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I request that payment under the above insurance program be made on my behalf to: Central Florida Heart Associates, PA on any bill for services provided to me by their physician(s) or staff member.**

**Subscriber Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥♥**

**Medicare Lifetime Signature Agreement**

**Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I request that payment under the above insurance program be made on my behalf to: Central Florida Heart Associates, PA on any bill for services provided to me by their physician(s) or staff member. I authorize release of any information to the Social Security Administration need for or related to a Medicare claim.**

**Subscriber Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**CENTRAL FLORIDA HEART ASSOCIATES, PA**

**Patient History Form**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Sex: M \_\_\_\_\_ F\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
|  **Review of Systems – Please check each item as they relate to your health history.** |

|  |  |  |  |
| --- | --- | --- | --- |
| **CONSTITUTIONAL** | **EYES** | **EARS, NOSE AND THROAT** | **GENITOURINARY** |
| * **Weight loss**
 | * **Glasses/contacts**
 | * **Vertigo**
 | * **Painful urination**
 |
| * **Weight gain**
 | * **Double vision**
 | * **Frequent sore throat**
 | * **Burning**
 |
| * **Fever**
 | * **Glaucoma**
 | * **Frequent Nosebleed**
 | * **Frequency**
 |
| * **Fatigue**
 |  |  |  |
| * **Change in Appetite**
 |  |  |  |
|  |  |  |  |
| **ALLERGIC/IMMUNOLOGIC** | **RESPIRATORY** | **GASTROINTESTINAL**  | **CARDIOVASCULAR**  |
| * **Hayfever**
 | * **Shortness of breath**
 | * **Abdominal pain**
 | * **Chest pain**
 |
| * **Asthma**
 | * **Coughing blood**
 | * **Nausea/vomiting**
 | * **Jaw pain**
 |
| * **Hives/Eczema**
 | * **Wheezing**
 | * **Heartburn**
 | * **Arm pain**
 |
|  | * **Persistent cough**
 | * **Rectal bleeding**
 | * **Calf pain**
 |
|  |  | * **Bloody/black stools**
 | * **Palpitations**
 |
|  |  | * **Diarrhea**
 | * **Swelling of extremities**
 |
|  |  | * **Constipation**
 |  |
|  |  |  |  |
| **HEMATOLOGIC** | **MUSCULOSKELETAL**  | **NEUROLOGICAL**  | **SKIN** |
| * **Bruise easily**
 | * **Joint pain/swelling**
 | * **Seizures**
 | * **Rash/sores**
 |
| * **Enlarged glands**
 | * **Stiffness**
 | * **Headaches**
 | * **Itching**
 |
|  | * **Muscle pain**
 | * **Numbness**
 |  |
|  | * **Back pain**
 | * **Memory loss**
 |  |
|  |  | * **Loss of consciousness**
 |  |
| **ENDOCRINE** |  | * **Sleep apnea**
 |  |
| * **Loss of hair**
 |  |  |  |
| * **Heat/cold intolerance**
 |  |  |  |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had any of the following tests/procedures? If yes, please list date and place.**

|  |  |
| --- | --- |
|  **TESTS/PROCEDURE** |  **DATE AND PLACE** |
| 1. **Cardiac stress test**
 |  |
| 1. **Heart catheterization**
 |  |
| 1. **Angioplasty or stent**
 |  |

**Past Patient History: Please list below ALL your past operations, hospitalizations, illnesses, or injuries.**

**Please be specific as to reason and date.**

|  |  |
| --- | --- |
|  **List all past operations or hospitalizations** **with reason, place and date** | **List all personal illnesses or injuries and dates.** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Past Patient History: Please check each item as they relate to your PAST personal history.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  **CONDITION** | **DATE** |  |  **CONDITION** | **DATE** |
|  |  ***INFECTIOUS DISEASES*** |  |  |  ***ENDOCRINE*** |  |
|  | Hepatitis |  |  | Diabetes |  |
|  | HIV/AIDS  |  |  | Thyroid problems |  |
|  | Polio |  |  |  ***GASTROINTESTINAL***  |  |
|  | Rheumatic fever  |  |  | Stomach ulcer |  |
|  | Tuberculosis  |  |  | Gallstones |  |
|  |  ***CARDIOVASCULAR*** |  |  | Liver disease  |  |
|  | High cholesterol  |  |  |  ***RENAL/GENITOURINARY***  |  |
|  | High blood pressure  |  |  | Kidney disease  |  |
|  | Birth defect of heart |  |  | Kidney stones  |  |
|  | Heart murmur  |  |  | Prostate problems |  |
|  | Irregular heartbeat |  |  | Urinary tract infections |  |
|  | Pericarditis  |  |  |  ***MUSCULOSKELETAL***  |  |
|  | Heart attack |  |  | Gout |  |
|  | Peripheral vascular disease |  |  | Arthritis  |  |
|  | ***PULMONARY AND NEUROLOGICAL***  |  |  | Back pain |  |
|  | Lung disease  |  |  | Herniated disk  |  |
|  | Prior pneumonia  |  |  |  ***HEMATOLOGY ONCOLOGY***  |  |
|  | Exposure to inhaling hazardous agents |  |  | Anemia |  |
|  | Stroke/transient ischemic attack  |  |  | Cancer – List type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Migraines |  |  | Blood clots |  |
|  | Seizure disorder |  |  | Bleeding problems |  |

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST FAMILY HISTORY: Please complete the following.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  **Age if Alive** |  **Health Problems** |  **Age at Death** |  **Cause of Death** |
| **Mother** |  |  |  |  |
| **Father** |  |  |  |  |
| **Siblings** |  |  |  |  |
| **Grandparents**  |  |  |  |  |

**CURRENT MEDICATIONS: Please list ALL current medications (include all prescriptions or over-the-counter medications**

**that you are currently taking).**

|  |  |  |
| --- | --- | --- |
|  **MEDICATION**  |  **DOSE** | **FREQUENCY (# OF TIMES PER DAY)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **Are there any medications which you stopped taking in the past month? If yes, which medications have you stopped?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Are you currently taking aspirin? If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **ALLERGIES: List all medications you are allergic to and the type of allergic reaction.**

|  |  |
| --- | --- |
|  **MEDICATION** |  **ALLERGIC REACTION** |
|  |  |
|  |  |
|  |  |
|  |  |

**SOCIAL HISTORY: Please answer the following questions.**

|  |  |
| --- | --- |
| **TOBACCO****Have you ever used tobacco?** **Yes \_\_\_\_\_ No \_\_\_\_\_****If yes, number of years smoked \_\_\_\_\_\_\_\_\_\_****Number of packs per day \_\_\_\_\_\_\_\_\_\_****If you have stopped smoking, when did you quit? \_\_\_\_** | **CAFFEINE** **Do you drink caffeine (coffee, soda, or tea)?** **Yes \_\_\_\_\_ No \_\_\_\_\_****How many cups per day? \_\_\_\_\_\_\_\_\_\_** |
| **RECREATIONAL DRUGS** **Do you use recreational drugs? If yes, what type. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **ALCOHOL** **Do you drink alcohol? \_\_\_\_\_\_\_****If yes, how frequently and quantity. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **EXERCISE****Do you exercise? Yes \_\_\_\_\_ No \_\_\_\_\_****Type of exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****How many times per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **MARITAL STATUS*** **Married**
* **Single**
* **Divorced**
* **Widow**
* **Widower**
 |
| **CURRENT OCCUPATION*** **Retired**
* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **TRAVEL****Have you recently travelled outside of the United** **States?** **Yes \_\_\_\_\_ No \_\_\_\_\_****If yes, where did you travel to and from?****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Do you have a:****Living Will****Yes \_\_\_\_\_ No \_\_\_\_\_****Health Care Proxy****Yes \_\_\_\_\_ No \_\_\_\_\_** | **IMMUNIZATIONS****Did you get vaccinated with the influenza flu vaccination** **(flu vaccine) this year?*** **Yes**
* **No**
 |

**I certify that the above information is correct to the best of my knowledge.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature Date**

**Patient Acknowledgement Receipt of Privacy Notice**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Patient’s name) hereby affirm that I have received a copy of the Notice of Privacy Practices from Central Florida Heart Associates, PA. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider. I understand that my signature on this Acknowledgement only signifies that I have received a copy of the Notice, and does not legally bind or obligate me in any way. I understand that I am entitled to receive a copy of the Notice of Privacy Practices from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient or Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Peripheral Artery Disease (PAD) ASSESSMENT**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FIRST NAME LAST NAME DATE OF BIRTH**

**Peripheral artery disease (PAD) is a common circulation problem in which arteries carrying blood to the legs are not functioning well or become narrowed or clogged due to a buildup of plaque.**

Fill out this questionnaire so your physician can evaluate whether you may be at risk or have symptoms of PAD.

Circle **YES** or **NO** on the following questions and check all boxes that apply.

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Have you ever been diagnosed with peripheral vascular disease or been diagnosed as having poor circulation?
 | **YES NO** | 6. If you have pain, does the pain subside with rest? | **YES NO** |
| 1. Have you ever had surgery, balloon procedures, or stents in your heart, kidneys, belly, legs, or arms?

If yes, dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **YES NO**  | 7. Do your feet or toes bother you most nights while lying in bed, with relief when they are dangled at the edge of the bed? |  **YES NO**  |
| 1. When you walk, do you experience aching, cramping or pain in your arms, legs, thighs, or buttocks?
 | **YES NO** | 8. Do you have any painful sores or ulcers on legs or feet that do not heal? | **YES NO** |
| 1. If you answered **YES** to #3, when do you feel the pain:
* After walking 1 block
* Climbing a flight of stairs
* After walking 100 yards
* Walking at increased speed
 |  | 9. Are your legs or arms pale, discolored, or bluish? | **YES NO** |
| 1. http://us.cdn2.123rf.com/168nwm/tsuneo/tsuneo1204/tsuneo120400120/13385760-human-body.jpg If you answered **YES** to #3, circle the area(s) of the body on the diagram below where you feel the pain.
 |  | 10. **Check all that apply*** I am a current smoker
* I have history of smoking
* I have diabetes
* I have a family history of diabetes
* I have high cholesterol
* I have a family history of high cholesterol
* I have high blood pressure/hypertension
* I have a family history of high blood pressure/hypertension
* I have coronary artery disease (CAD)
* I have a family history of coronary artery disease
* I have had a stroke/mini stroke/TIA
* I have a family history of stroke/mini stroke/TIA
 |  |

**Notice of Privacy Policies for Central Florida Heart Associates, PA**

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**Introduction**

At **Central Florida Heart Associates, PA.,** we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected heal information. This Notice is effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and applies to all protected health information as defined by the federal regulations.

**Understanding Your Health Record/Information**

Each time you visit **CENTRAL FLORIDA HEART ASSOCIATES, PA,** a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

* Basis for planning your care and treatment,
* Means of communication among the many health professionals who contribute to your care,
* Legal document describing the care you received,
* Means by which you or a third-party payer can verify that services billed were actually provided,
* A tool in educating health professionals,
* A source of data for medical research,
* A source of information for public health officials charged with improving the health of this state and the nation,
* A source of data for our planning and marketing,
* A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information and make informed decisions when authorizing disclosure to others.

**Your Health Information Rights**

Although your health record is the physical property of **CENTRAL FLORIDA HEART ASSOCIATES, PA,** the information belongs to you. You have the right to:

* Obtain a paper copy of this notice of information practices upon request,
* Inspect and copy your health record as provided for in 45 CFR 164.524,
* Amend your health record as provided in 45 CFR 164.528,
* Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
* Request communications of your health information by alternative means or alternative locations,
* Request a restriction on certain uses and disclosures of your information s provided by 45 CFR 164.522, and
* Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

**Our Responsibilities**

CENTRAL FLORIDA HEART ASSOCIATES, PA is required to:

* Maintain the privacy of your health information,
* Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
* Abide by the terms of this notice,
* Notify you if we are unable to agree to a requested restriction, and
* Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except ASD described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedure included in the authorization.

**For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the practice’s Privacy Officer at (386) 774-2100, extension 14.

If you believe your privacy rights have been violated, you can file a complaint with the practice’s Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer of the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue SW

Room 509F, HHH Building

Washington, DC 20201

**Examples of Disclosures for Treatment, Payment, and Health Operations**

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions hey took and their observations. In that way, the physician will know how you are responding to treatment.

**We will use your health information for payment.**

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information total hip arthroplasty identifies you, as well as your diagnosis, procedures, and supplies used.

**We will use your health information for regular health operations.**

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

***Business associates:*** There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use making copies of your health record. When these services are contracted, we may disclose your health information to our business associated so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associated to appropriately safeguard your information.

***Directory:*** Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

***Notification:*** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

***Communication with family:*** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify health information relevant to that person’s involvement in your care of payment related to your care.

***Research:*** We may disclose information to researches when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

***Funeral directors:*** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

***Organ procurement organization:*** Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

***Marketing:*** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you***.***

***Fund raising:*** We may contact you as part of a fund-raising effort.

***Food and Drug Administration (FDA):*** We may disclose to the FDA health information relative to adverse events with respect to food, supplement, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

***Workers compensation:*** We may disclose health information to the extent authorized by and to the extent necessary to comply with law relating to workers compensation or other similar programs established by law.

***Public health:*** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

***Law enforcement:*** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.