Samantha R. Avery, DO
Lilian Ahiable, MD, FACC
George Degheim, MD, FACC
Jamie Caballero, MD, FACC
Ali Abdual Jabbar, MD
Konstantinos Marmagkiolis, MD
Usama Mukayed, MD, FACC
James R. Post, MD, FACC
Robert Sanchez, MD, FACC

www.theheartinst.com

John W. Walsh, MD, FACC, FSCAI
Christopher H. Wilson, DO,FACC

Electrophysiology
Francisco Cardona, MD, FACC, FHRS
Marshall Marcus, MD
Robert C. Sheppard, MD, FACC, FHRS

PATIENT REGISTRATION FORM

Patient's Legal Name: (Last)_____________________________ (First)________________________ (MI) _______

Preferred Full Name (if different from above): ________________________________

Gender Identity: ❑ Female ❑Male ❑Transgender Female to Male ❑ Transgender Male to Female ❑Genderqueer ❑Choose not to disclose ❑Additional Gender category not listed __________________________

Local Address: ____

City:______________________________________State:______________Zip: __________________________

Home Phone (Landline)_____________________ Work Phone_________________ Cell Phone: ________________

Email: ____

Date of Birth:_______________________________Age:__________SS#:______________________________

Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Choose not to disclose

Preferred Language: ❑English ❑ Spanish ❑ASL ❑Japanese ❑Mandarin ❑Korean ❑French ❑Indian: Hindi, Tamil, Gujarati etc. ❑ Swahili ❑Russian ❑ Arabic ❑Vietnamese ❑Haitian Creole ❑Bosnian/Croatian/Serbian/Serbo-Croatian ❑Albanian ❑ Burmese ❑Tagalog ❑ Farsi-Iranian/Persian ❑Portuguese ❑Cambodian ❑Other not listed______________________

Race: ❑American Indian or Alaska Native ❑Hispanic ❑Native Hawaiian or Other Pacific Islander ❑Asian ❑ White ❑Black or African American ❑Other_____ ❑Choose not to disclose

Marital Status: ❑Single ❑ Married ❑Divorced/Separated ❑Widowed

Employed: ❑Full Time ❑Part-time ❑Unemployed ❑Disabled ❑Retired ❑Military

Employer:__________________________________Job Title: ____

Local Pharmacy Name: _________________________Address: _____________________________________

Family Doctor:______________________________Referring Doctor: _________________________________

Primary Insurance:________________________**Secondary Insurance:** ___________________________

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐ Responsible party name: (Last)________(First) ____(MI) ________________________

Date of birth:MM___/DD____/YYYY____ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_________-________-___________Phone number: ___________

Address:____

City, State:_________________________ZIP: _______________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)___________________________ (First) ____________________________

Phone number:____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_________________________________☐ Guardian

Address____

City, State:_________________________ZIP: _______________

Home phone:________________________Work hone:_____________Ext. _____

Whom may we thank for referring you to us?

❑ Friend/Family ❑ Postcard/Mailer ❑ Letter ❑ Consult A Nurse ❑ Hospital______________________

❑ Physician referral_____ ___________________❑ Insurance______________________

Internet: ❑ Google Plus ❑ Facebook ❑ Vitals ❑ Healthgrades ❑ Yelp ❑Theheartinst.com

I hereby authorize The Heart Institute to release all or part of my medical records to Medicare and/or any other companies, if requested, without any liability to The Heart Institute. I hereby authorize Medicare and/or my insurance companies to pay directly to The Heart Institute any payments, assignments or benefits due me.

____ ________________

Patient Signature Date

Reason for Today's Visit? ______________________________

PAST MEDICAL HISTORY:

Please list any previous illness, hospitalizations or surgeries, and the year:
1. ______________________________
_
2. ______________________________
3. ______________________________
_
4. ______________________________
5. ______________________________

Ple_ase list any medications you are currently taking:
Name, strength, frequency
1.______________________ 7. ______________________
2.______________________ 8. ______________________
3.______________________ 9. ______________________
4.______________________ 10. ______________________
5.______________________ 11. ______________________
6.______________________ 12. ______________________

ALLERGIES **Do you have allergies to drugs, food, latex, dye?** **YES** **NO**

Allergy - list medication, food, latex, dye, etc.	Reaction - rash, shortness of breath, hives, itching, etc

Have you seen a cardiologist in the past? If "yes":

Name______________________Location ______________________

Have you been told you have any of the below? Yes_____No ______

Angina, Mitral Valve Prolapse, Heart Murmur, TIA's, Diabetes, High Blood Pressure, Heart Attack (circle) Date________________.

Have you ever had any of the following procedures? Please tell us when.

Heart Catheterization______________________Angioplasty ______________________
Coronary Bypass______________________Exercise Test ______________________
Echocardiogram______________________Holter Monitor ______________________
Do you know your cholesterol level? ______________________

FAMILY HISTORY

Living	Age	Health Status
Father		
Mother		
Sisters		
Brothers		
Deceased	**Age at Death**	**Cause of Death**
Father		
Mother		
Sisters		
Brothers		

Do you have a Family History of?

Diabetes High Cholesterol Stroke Cancer Heart Attack

Social History

Are you: Married Single Divorced Widowed

Number of Children?________________________Ages ____

Do you smoke? Yes_____No_____How much_______How Long_______Year Quit _____________

Do you drink alcohol? Yes_____No______how much per week? ___________________________________

Do you exercise? Yes_____No______What do you do?____________________Frequency__________

Do you have a living Will? Yes_____No_____ Advance Directive ___________________________

Please circle if it applies to you:

Eyesight: Good - Fair - Poor - Glaucoma

Ears, Nose, Throat: Poor Hearing - Sore Throat - Sinus Problems

Gastrointestinal: Swallowing Problems - Indigestion - Ulcers Hiatal Hernia - Bloody stools - Diarrhea

Genitourinary: Difficulty Urinating - Blood in Urine - Prostate Problems - Kidney problems – Postmeno.

Musculoskeletal: Muscle Pain - Joint pain - Arthritis

Integumentary: Skin Rash - Skin Disorders

Neurological/Psychiatry: Fainting - Depression - Anxiety - Drug Dependence

Endocrine: Thyroid Disease - Diabetes

Hematologic/Lymphatic: Taking Blood Thinners - Taking Aspirin - Coumadin

Allergic/Immunologic: Sinusitis - Hayfever - Allergies

Please answer the questions in the following sections, if they apply to you

Chest Pain

Do you have Chest Pain? Yes______No______If *yes* answer questions 1-9. If *no* move to the next section.

1. How long have you had chest pain? ____
2. Location of chest pain? ____
3. Radiation of chest pain: none, left arm, left shoulder, right arm, right shoulder, jaw, back (circle)
4. Character of pain: dull, pressure, heaviness, sharp (circle)
5. Duration of episodes: seconds, minutes, hours, constant (circle)
6. Severity of pain 0-10 (zero being pain free) _________
7. Do you have pain with: exercise, resting or both? (circle)
8. Do you have any of the following with your pain? Shortness of breath, nausea, palpitations or sweating

Peripheral Arterial Disease

1. When you walk or exercise, do you experience discomfort (aching, cramping or pain) Yes/No
   A. If you answered yes, does the discomfort subside with rest? Yes/No
2. Have you ever had surgery, balloon procedures, or stents to any blood vessels other than your heart? Yes /No
3. Do you have painful sores or ulcers on your legs or feet that are not healing? Yes/No
4. Are your toes or feet pale, discolored, or bluish? Yes/No
5. Have you ever been told by a physician that you have poor circulation? Yes/No

Shortness of Breath

Do you have shortness of breath? yes_____no_____If *yes* answer questions 1-9. If *no* move to the next section.

1. How long have you had shortness of breath? ____
2. What makes you short of breath? ____
3. Do you wake up at night short of breath? never, rarely, every night (circle)
4. Do you get up to urinate at night? yes_____no _____
5. Do you tire easily? yes_____no _____
6. Do you have leg or ankle swelling? yes_____no _____
7. Do you have wheezing? yes_____no _____
8. Do you have a cough? yes_____no_____Sputum production? yes_____no _____

Palpitations

Do you have palpitations? yes_____no_____If yes answer questions 1-5. If *no* move to the next section.

1. How long have you had palpitations? ____
2. Does your heart feel like: skipping beats, racing, beating fast & regular, beating fast & irregular? (circle)
3. Do your palpitations occur with any of the following: rest, exercise, excitement, alcohol, caffeine? (circle)
4. Are you under a lot of tension and stress? yes_____no _____
5. Do you have other symptoms with your palpitations? none, dizziness, fainting, shortness of breath, nausea, sweating, lightheadedness (circle)

Patient Signature:____ **Date:** ________________________

PHYSICIAN SIGNATURE: ____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________	______________________________
Signature of Patient or Personal Representative	**Date**
______________________________	______________________________
Printed Name of Patient or Personal Representative	**Relationship to Patient**
______________________________	______________________________
Printed Name of Witness	Employee Job Title
______________________________	______________________________
Signature of Witness	**Date**

The Heart Institute			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

________ (**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

A photocopy of this consent shall be considered as valid as the original.

The Heart Institute			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic]

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

PATIENT NAME____ **DATE OF BIRTH**_____________

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. ___________**(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **The Heart Institute** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. __________**(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **The Heart Institute** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. __________**(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **The Heart Institute** any insurance or other third-party benefits available for health care services provided to me. I understand **The Heart Institute** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **The Heart Institute,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____________**(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **The Heart Institute** by the Medicare or Medicaid program.

5. _____________**(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for, **The Heart Institute** or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **The Heart Institute** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **The Heart Institute** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____________**(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X____Date_______________

If you are not the Patient, please identify your Relationship to the Patient. Please circle which apply

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify__________________________________

First Point of Contact Screening

Patient Name___________________________________ **DOB**__________________

Please print full legal name

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing your hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissue, masks, hand sanitizer, and Band-Aids.

1. Do you have any of the following symptoms? YES NO

If yes, please circle the symptoms you have now, or have had, over the past seven days?

- ☐ **Fever**
- ☐ **Night sweats**
- ☐ **Sneezing or runny nose**
- ☐ **Cough**
- ☐ severe headache
- ☐ stiff neck
- ☐ muscle or joint pain (circle one or both)
- ☐ new rashes or open sores on your skin or in your mouth
- ☐ redness, swelling, or discharge of your eyes (pink eye)
- ☐ unexplained bleeding
- ☐ vomiting or diarrhea

2. In the past three weeks, have you traveled outside the U.S.? YES NO

   If yes, please list where: ____

3. In the past three weeks have you had close contact with someone who has traveled outside the U.S.? YES NO

   If yes, please list where: ____

TO BE FILLED OUT BY OFFICE STAFF

Reviewed by:____

Action taken:

- ☐ No action taken
- ☐ Isolate
- ☐ Cough/ hand washing etiquette provided
- ☐ Mask provided
- ☐ PM/ Lead clinical notified

____ ______________________________

Signature of Patient or Personal Representative **Date**

Thank you for trusting us with your healthcare!