HEART CARE CENTER OF NORTHWEST HOUSTON PATIENT INFORMATION SHEET

Patient Name: _____ _____ _____
First Middle Last

Address: _____ _____ _____
Street City Zip

SS#: _____ **BD:** ___/___/_____ **SEX:** ☐ F ☐ M **Marital Status:** ☐ S ☐ M ☐ W ☐ D

Phone:
HM: _____ **WK:** _____ **CELL:** _____

Employer: _____ ☐ Full ☐ Retired ☐ Student ☐ Unemployed

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

PRIMARY INSURANCE

Ins Co Name: _____ **Benefit Phone #:** _____

Policy/ID #: _____ **Group #:** _____

Insured Name: _____ ☐ Self ☐ Spouse ☐ Mother ☐ Father

Insured BD: ___/___/_____ **Insured SS#:** _____ **Insured Employer:** _____

SECONDARY INSURANCE

Ins Co Name: _____ **Benefit Phone #:** _____

Policy/ID #: _____ **Group #:** _____

Insured Name: _____ ☐ Self ☐ Spouse ☐ Mother ☐ Father

Insured BD: ___/___/_____ **Insured SS#:** _____ **Insured Employer:** _____

I, the undersigned, authorize payment of medical benefits to any treating physician at The Heart Care Center of NW Houston for any services rendered and that I am responsible for payment of all services rendered in the event that my insurance company does not pay.

_____ ___/___/_____
Patient's Signature **Date**

FEDERALLY MANDATED ELECTRONIC HEALTH RECORD

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____

Date of Birth: ___/___/_____

The Heart Care Center wants to make communicating with our patients as convenient for you as possible. We will be using an automated appointment confirmation system which will contact you by phone. This system will be tailored to your preferred method of communication - either voice or text. For this purpose, please choose one of the following options:

CHOOSE ONLY ONE OPTION BELOW:

Option # 1 -I want to be contacted by a voice phone message:

Preferred Phone #: _____ ◯ Home ◯ Cell ◯ Work

Option #2 - I want to receive a text (SMS) message:

Cell Phone #: _____

Preferred Language: ◯ English ◯ Spanish

Preferred Time: ◯ Morning ◯ Afternoon ◯ Evening

Email Address: _____

Please answer these additional questions to complete your patient record with our office to comply with recent Federal mandates:

Race:

- ☐ Black
- ☐ Hispanic or other Latin
- ☐ White
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Native Alaskan
- ☐ American Indian
- ☐ Other Race
- ☐ Unreported

Ethnicity:

- ☐ Caucasian
- ☐ Hispanic
- ☐ African American
- ☐ Asian

Language:

- ☐ English
- ☐ Spanish
- ☐ Indian (includes Hindi & Tamil)
- ☐ Chinese
- ☐ Japanese
- ☐ Vietnamese

I give permission for my doctor to review my prescription history when prescribing medications: ◯ Yes ◯ No

HEART CARE CENTER OF NORTHWEST HOUSTON
NEW PATIENT QUESTIONAIRE

NAME: _____ **DATE:** _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING DR:** _____
(If different from PCP)

HOSPITAL FOLLOW UP FROM:

☐ Methodist Willbrook ☐ Methodist Cypress ☐ St. Luke Vintage ☐ HCA North Cypress ☐ Other: _____

CHIEF COMPLAINT (Reason for visit): _____

PAST MEDICAL HISTORY:

(Illnesses or diseases): Please circle all that apply

☑ CAD (heart disease)	☐ Valvular Heart Disease (heart murmur)	☐ Arrhythmias	☐ CMOP/CHF (weak/enlarged heart)	☐ PVD (poor circulation/blockages)
☐ MI (heart attack)	☐ Rheumatic Fever	☐ Atrial Fibrillation (A. Fib)	☐ AICD (defibrillator)	☐ CEA (clean out neck arteries)
☐ Coronary Angiogram (heart cath)	☐ Scarlet Fever	☐ SVT (supraventricular tachycardia)	☐ Hypertension (high blood pressure)	☐ Peripheral Bypass (Leg artery bypass)
☐ Angioplasty (balloon procedure)	☐ Aortic Valve ☐ Replacement ☐ Repair ☐ Bioprosthetic ☐ Mechanical	☐ Bradycardia (slow heart rate)	☐ Dyslipidemia (abnormal cholesterol)	☐ Peripheral Stents (leg or kidney or neck)
☐ Stents (in heart)		☐ Tachycardia (fast heart rate)	☐ CVA (stroke)	☐ Peripheral Angioplasty (leg or kidney or neck balloon)
☐ CABG (coronary bypass)	☐ Mitral Valve ☐ Replacement ☐ Repair ☐ Bioprosthetic ☐ Mechanical	☐ PPM	☐ TIA	
Other: _____ (coronary artery bypass)		(pacemaker)	(mini-stroke)	
☐ Diabetes ☐ Type 1 ☐ Type 2		☐ Medtronic ☐ Guidant ☐ St. Jude ☐ Other: _____	☐ Thyroid Problems ☐ Too High ☐ Too Low	
☐ Obesity	☐ Ablation			

PAST SURGICAL HISTORY (Operations): _____

FAMILY HISTORY:

Please circle all that apply

☐ CAD ((heart disease in family members before the age of 55)
☐ HTN (high blood pressure)
☐ HCOL (high cholesterol) ☒ CVA (stroke)
☐ DM (diabetes)
☐ Valvular disease
☐ Other: _____

SOCIAL HISTORY:

Please fill in the blanks or circle as necessary

Tobacco Use (smoking or chewing): ◯ Yes ◯ No ◯ Never ◯ Quit ☐ yrs ago ☐ PPD (packs/day)
Alcohol Use: ◯ Yes ◯ No
Number of drinks per week _____
Recreational Drug Use: ◯ Yes ◯ No

Occupation: _____ **Living Status:** _____ **Marital Status:** _____

Exercise: ◯ Yes ◯ No

Healthy Eating Habits? ◯ Yes ◯ No

HEART CARE CENTER OF NORTHWEST HOUSTON

ALLERGIES:
Medications:

Foods:

Environmental:

MEDICATIONS:	NAME	DOSE	FREQUENCY

HEART CARE CENTER OF Northwest Houston, PA

Authorization for the Release of Protected Health Information to a Family Member, Friend or Personal Representative

- Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share your health information with the person you have indicated below.
- This authorization is voluntary.
- Right to revoke: If you decide, you do not want us to share your health information any longer, sign the revocation at the end of this form and give this form to the front desk. If we have shared your health information for a research study, we may continue to use or share your health information for that purpose only.
- Payment, enrollment or eligibility for benefits for your health care will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- We cannot promise that the person you permit us to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this authorization, and can contact our privacy office to get a copy if you do not have one.

Print Name: _____

Social Security Number: _____ **DOB:** _____

I give permission to The Heart Care Center of Northwest Houston, PA to share my health information with:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

The Heart Care Center of Northwest Houston, PA may share my health information on this authorization form until this date of ____ / ____ / ____ *, or until I revoke the authorization in writing.*

HEART CARE CENTER OF NORTHWEST HOUSTON
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient: _____ **Date of Birth:** _____
(Please Print)

The Privacy Practices Document of The Heart Care Center of Northwest Houston, PA is available for your review upon request.

As a patient you acknowledge by your signature below that you have the right to review our Patient Privacy Practices. The Heart Care Center of Northwest Houston, PA will use and disclose your health information to any physician, pharmacy, hospital, insurance company or other healthcare provider that is necessary for your treatment, payment and healthcare operations.

You have the option of allowing us to disclose your health information to a family member, friend or other person as necessary to help with your healthcare or payment for your healthcare. A form for this purpose will be provided to you by our office. This authorization to disclose your healthcare information is effective for lifetime unless revoked or terminated earlier by the patient or the patient's legal representative in writing.

Acknowledgement:

I acknowledge that I have the right to review the Privacy Practices of The Heart Care Center of Northwest Houston, PA upon my request to do so.

_____
Patient or Legal Representative's Signature and Relationship to Patient

Date _____

Office Use Only:

We did not receive written acknowledgement due to:

- ☐ Patient or Representative refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other _____

Part 2
Authorization for the Release of Protected Health Information cont'd

I request that the following health information be shared:

Option 1:

☐ All of my health care information can be shared.

Option #2:

☐ My health care information can be shared with the exception of the following
(Please check any items below you do not want us to share):

☐ Information regarding prescription drug coverage

☐ Information regarding treatment for drug or alcohol abuse

☐ Information regarding behavioral health services or psychiatric care

☐ Information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)

☐ Other: _____

This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Patient: _____ **Date:** _____

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a power of attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative: _____ **Date:** _____

Relationship to Patient: _____

HEART CARE CENTER OF NORTHWEST HOUSTON, PA

IMPORTANT ITEMS TO BRING WITH YOU THE DAY OF YOUR VISIT

- ☐ COPIES OF ANY LAB WORK THAT YOU HAVE HAD DONE IN THE PAST 12 MONTHS
- ☐ COPY OF YOUR LAST EKG (ELECTROCARDIOGRAM)
- ☐ BRING ALL YOUR MEDICATION BOTTLES THAT YOU ARE CURRENTLY TAKING
- ☐ BRING YOUR PRIMARY INSURANCE CARD
- ☐ BRING YOUR SECONDARY INSURANCE CARD, IF APPLICABLE
- ☐ BE PREPARED TO PAY YOUR CO-PAY WHEN YOU CHECK IN, IF APPLICABLE
- ☐ IF YOUR PRIMARY INSURANCE PLAN REQUIRES A REFERRAL, PLEASE MAKE SURE YOU BRING A COPY OF THE CURRENT REFERRAL WITH YOU
- ☐ IF YOU WERE REFERRED BY YOUR PHYSICIAN FOR A DIAGNOSTIC TEST ONLY, PLEASE BRING A COPY OF THE ORDER FORM FROM YOUR DOCTOR THAT STATES WHAT TYPE OF SERVICE HE/SHE IS REQUESTING

THANK YOU !!!!