HeartCare Texas

Cardio Vascular Specialists

___Mr. ___Mrs. ___Miss ___Ms. ___Dr.

Last Name: _____ First: _____ M: _____

Address: _____

City: _____ State: _____ Zip: _____

Best day time phone number: _____

Alternate: _____

Primary Care Provider: _____

Referring provider, if other than PCP: _____

Date of Birth: _____/_____/_____ _____Male _____Female _____ Transgender

Email address: _____

Race: ___American Indian, Alaskan Native ___Asian ____Native Hawaiian, Pacific Islander ___Black/African American ___White ___Hispanic ___Other ___Declined

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Declined

Language: ___English ___Spanish ___ Any other. ___ Is a translator requested at appts.?

Marital Status: _____ Social Security Number: _____

Employer Name: _____ Employment Status: _____

Student: ____Yes, ____Full time ____Part time ____Not a student

Emergency Contact: Last Name: _____ First Name: _____

Phone Number: _____ Relation: _____

____ Do You Have a Living Will?

RESPONSIBLE PARTY

____ Self ____ Guarantor

Patient Name: _____ DOB: _____

LOCAL:

Pharmacy Name: _____

Address: _____

_____

Phone #: _____

MAIL ORDER: _____

Guarantor Name: Last: _____ First: _____

Latex Allergy: _____

MEDICATION PRESCRIPTION POLICY & AGREEMENT:

If you need a refill on your medication, we ask that you call the pharmacy. They will then send a refill request electronically to us. If you do call us, we will ask you to call the pharmacy.

We do not refill medication after hours or on weekends. Our providers do not have access to your records when they are away from the office. Please call the pharmacy at least 3 days before you need the medication. Our providers need time to process the requests.

Any refills sent to us after the 3:30 PM will be processed the next business day.

OFFICE HOURS:

We will be open Monday thru Friday between the hours of 8:00 AM & 5:00 PM. We do not close for lunch.

As always, if you feel you are in an emergent situation, hang up & dial 911.

FINANCIAL AGREEMENT:

*I acknowledge that HeartCare Texas may bill my insurance company for services provided to me.

*I agree to pay for services that are not covered or covered charges that are not paid in full by the insurance company. These charges can include any co-pays, co-insurance, and/or deductibles.

*I acknowledge that HeartCare Texas may use the services of a third-party business associate or affiliated entity as an extended business office for medical account billing and servicing.

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

*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 HeartCare Texas by the Medicare or Medicaid program.

*Consent to telephone calls for financial communications. I agree that, in order for HeartCare Texas or extended business office (EBO) servicers & collection agents, to service my

account or to collect any amounts I may owe. I expressly agree and consent that Heartcare Texas or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or HeartCare Texas 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 prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

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

Patient/Patient Representative: _____ Date: _____

If you are not the patient, please identify your relationship to the patient.

_____

New Patient History:

Patient name: _____ DOB: _____ Date: _____

Describe your main problems:

List any allergies or adverse reactions:

Drug/Allergen:	Reaction:	Onset:
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____NKDA (no known allergies)

List all current medications, dosage & reason:

Name:	Dosage:	Reason:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all providers you are currently seeing:

Name:	Specialty:
_____	_____
_____	_____
_____	_____
_____	_____

Past medical history:

___ Other: _____	___ Anxiety Disorder	___ Aortic Aneurysm
___ ADD or ADHD	___ Arrhythmia	___ Arthritis
___ Allergies	___ Anemia	___ Asthma
___ A Fib	___ Back Pain	___ Bedwetting

___ Birth defect or inherited disease
___ Bleeding disorder
___ Blood Clots
___ Breast cancer
___ CAD
___ COPD
___ Heart Problems
___ Heart Valve Disorder
___ Heart attack
___ Heart Murmur
___ Hemophilia
___ Hepatitis
___ Hernia
___ Hiatal Hernia
___ Hypercholesterolemia
___ Hyperlipidemia
___ Hypertension
___ Hyperthyroidism
___ Hypothyroidism
___ Joint Pain
___ kidney disease
___ Kidney Stones
___ Leg or foot ulcers
___ CVA
___ Cancer
___ Chest Pain
___ Chicken Pox
___ Claustrophobia
___ congenital heart disease
___ Congestive Heart Disease
___ Constipation
___ Depression
___ Development/Behavioral
___ Diabetes
___ Diverticulitis
___ Ear/Hearing problems
___ Eczema, Hives, skin issues
___ Endometriosis
___ Epilepsy
___ Fibromyalgia
___ GERD
___ Gastro Disease
___ Genitourinary Disease
___ Gout
___ HIV or AIDS
___ Head Trauma
___ Headaches or migraines
___ Liver disease
___ Obesity
___ Organ transplant
___ Osteoarthritis
___ Osteopenia
___ Pacemaker
___ Pulmonary Embolism
___ Rheumatoid arthritis
___ Seizures
___ Short of breath
___ Sleep apnea
___ Stroke
___ Thyroid problems
___ Tuberculosis
___ Ulcers
___ UTI
___ Alcohol or drug abuse

Family History:

Family member:	Disease:	Onset:	Died:
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____

Spouse: _____ _____ _____

Children: _____ _____ _____

_____ _____ _____

_____ _____ _____

Other: _____ _____ _____

Surgical History:

Procedure: Surgery Date:

_____ _____

_____ _____

_____ _____

Patient Social History:

Smoking status-select one:

___ Never ___Current everyday smoker ___Former Smoker ___ Current occasional smoker

Smoking how much: _____ pack per day ____ years of use

Occupation: _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Separated ___Widowed

___ Domestic Partner

Exercise Level: ___ None ___ Moderate ___ Occasional ___ Heavy

Diet: ___Regular ___ Vegetarian ___ Vegan ___ Gluten Free ___ Specific

___ Carbohydrate ___ Cardiac/Diabetic

General Stress Level: ___ Low ___ Medium ___High

Alcohol Intake: ___ None ___ Occasional ___ Moderate ___ Heavy

___ Years of use

Caffeine Intake: ___ None ___ Moderate ___ Occasional ___ Heavy

Chewing tobacco: ___ None ___ 1/day ___ 2-4/day ___ 5+/day

Illicit drugs:

_____

_____

_____

Passive Smoke exposure: _____

Family History of heart disease?	Yes	No
Family history of heart disease before Late 50's?	Yes	No
At risk for hep B?	Yes	No
At risk for TB?	Yes	No