NEW PATIENT INFORMATION FORM

Michael Metzger MD
Charles Harring MD
Andres Ruiz MD
Gustavo Cardenas MD
Heidi Templin ARNP

Patient name: ________________________________ **Today's Date:** ____ / ____ / ____
First ***Last***

Referred by: ______________________ Primary care physician: ____________________

Date of Birth: ____________ Gender: Male / Female SSN: ___________________

Home Address: ____
(City) (Zip code)

Home Phone: ________________________ Cell Phone: ________________________

Email Address: ____

Secondary Address: ____
(City) (Zip code)

Emergency Contact **name** and **phone number**: ____________________________________

Emergency Contact Relationship: ____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
❑ Domestic Partnership ❑ Other

Occupation: __________________________ Retired? ❑ Yes ❑ No

The U.S. Government requires that we ask the following questions. If you do not wish to answer these questions, please respond with "Decline". Check one of the following:

What is your ethnicity? ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Decline

What is your race? ❑ White ❑ African American/Black ❑ American Indian/ Alaska Native

❑ Asian ❑ Nat. Hawaiian/Pacific Islander ❑ Other Race

PHARMACY INFORMATION:

Preferred pharmacy name: ____

Preferred pharmacy address (Street & City): _______________________________

Preferred pharmacy phone #: ____

INSURANCE INFORMATION:

Primary insurance: _____________________ Policy/ID number: ______________________

Secondary insurance: ___________________ Policy/ID number: ______________________

ATTENTION – ALL PATIENTS

If your insurance plan requires a referral or authorization from your Primary Care Physician (PCP), it is your responsibility to have the referral or authorization at the time of visit. Please contact your PCP at least one week prior to your appointment.

If you do not have your referral at the time of your appointment, your doctor will be unable to see you and your appointment will be rescheduled.

As a courtesy, we ask that you give us at least 24 hours' notice if you need to cancel your appointment.

Your copay or deductible is due at this time of service.

_______________________________ _______________________

Patient Signature Date

BILLING AND CLAIMS PURPOSES

I hereby authorize South Palm Cardiovascular Associates to release my medical records to my health insurance company upon request by the insurance company. This includes progress notes, procedural information, hospital notes, medication list, or any additional information in regards to my medical health. I understand that this authorization, except for any action already take, may be voided by me at any time.

________________________________ ____________________

Signature of Patient or Legal Representative Date

PATIENT FINANCIAL RESPONSIBILITY

I authorize South Palm Cardiovascular Associates to submit claims to Medicare and/or other third party payers (Insurance Companies) in exchange for medical related services provided.

I further understand that I am ultimately financially responsible for any charges allowed by Medicare or the third party payers, not paid my Medicare or third party payers, such as annual deductibles and/or coinsurance (co-pays).

I understand there may be times when a service is not approved or covered by one of the above entities. By my signature below, I choose to obtain these medically related services from South Palm Cardiovascular Associates with the knowledge that I will be financially responsible for the charges of those services.

If I do not or cannot understand this agreement of financial responsibility, then my authorized representative or medical proxy or power of attorney agrees and understands this financial responsibility, and will sign on my behalf.

____________________________	____________________________
Patient Name (print)	Authorized Representative (if applicable)
____________________________	____________________________
Patient Signature	Date

South Palm Cardiovascular Associates
CONSENT FOR USE & DISCLOSURE
OF HEALTH INFORMATION

SECTION A: PATIENT PROVIDING CONSENT

Name: ______________________________________ SSN: _______________________

Address: ____

Telephone number: ______________________________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
Purpose of Consent: By signing this form, you will consent to our use & disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations of the uses & disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of our Privacy Practices. If we change our privacy practices, we will issue a revised Notice, which will contain the changes.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not effect any action we took in reliance of this Consent before we received your revocation and we may decline to treat you or to continue treating you if you revoke this consent.

I authorize my medical information to be shared with the following individual(s):

Name(s): ____

Relationship: ____

Signature:

I, ____________________________________, have had full opportunity to read and consider contents of this consent form & your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use & disclosure of my protected health information to carry out treatment, payment activities & healthcare operations.

Signature: ____ Date: _____________________

SOUTH PALM CARDIOVASCULAR ASSOCIATES
MEDICAL RECORD RELEASE

I, ______________________________________ request all / recent cardiac medical records including but not limited to: EKG'S, Echocardiograms, Stress test (stress echo or nuclear stress test), Non-Invasive &/or invasive vascular imaging results/findings, Cardiac cath & interventional Cardiology procedure reports, Pacer/ICD information, lab work, physician progress note and any other information that pertains to my health be sent to:

Michael Metzger M.D.
Charles Harring M.D.
Andres Ruiz M.D.
Gustavo Cardenas M.D.
Heidi Templin ARNP

13550 Jog Rd STE 204
Delray Beach, FL. 33446
Phone: (561) 515-0080
Fax: (561) 303-2135

Print name: ____

Date of birth: ___________________________

Signature of patient: ____

PAST MEDICAL HISTORY INFORMATION

Check **ALL** that apply and provide any explanation/dates.

Anemia		**Atrial Fibrillation**	
Asthma		**Atrial Flutter**	
Autoimmune Disease (IE Lupus, Sjogren, etc.)		**Benign Prostatic Hyperplasia (BPH)**	
Cancer (if so, what type?)		**Cirrhosis / Liver disease**	
Chronic pains? If yes, where?		**Chronic kidney disease**	
Congestive heart failure		**COPD/Emphysema**	
Crohn's Disease		**Colitis**	
Coronary Artery Disease		**CVA / TIA / STROKE**	
Deep vein thrombosis (DVT)		**Dementia/ Memory disorder**	
Dermatitis / Rash		**Diabetes**	
GI Bleeding		**Grave's Disease**	
GERD (heartburn)		**Glaucoma**	
Gout		**Heart Attack**	
Hemodialysis		**Hyperlipidemia**	
Hypertension		**Kidney Stones**	
Lymphoma / Leukemia		**Macular Degeneration**	
Parkinson's		**Peripheral Neuropathy**	
Pleural Effusion		**Pneumonia**	
Pulmonary Hypertension		**Rheumatoid Arthritis**	
Seizures		**Tremors**	
Thyroid Disorder (if yes, what type)		**Valvular heart disease**	
Venous Insufficiency / Varicose veins / Spider Veins		**Urinary/Vaginal Bleeding**	

Please explain the above past medical history:

____

____

____

PAST SURGICAL HISTORY:

Surgery (explain)	Date

MEDICATIONS:

Drug	Dosage	Frequency

FAMILY HISTORY

	Mother	Father	Sibling
Arrhythmia			
Blood clots/deep vein			
Cancer			
CAD			
CVA/Stroke/TIA			
High Cholesterol			
Myocardial Infarction(Heart Attack)			
Sudden Death			
Hypertension			
Unknown			

ALLERGIES:

Medications: ❑ No ❑ Yes (Explain): ________________________________

Food: ❑ No ❑ Yes (Explain): ________________________________

Allergic to latex: ❑ No ❑ Yes

SOCIAL HISTORY:

1.) Do you drink Alcohol? ❑No ❑Yes, if so how much per day? _________.
❑Former (How long ago did you quit? _________)

2.) Do you smoke cigarettes or tobacco? ❑No ❑Yes, if so how much per day? _________.
❑Former (How long ago did you quit? _________)

PRIOR CARDIAC TESTING:

Echocardiogram: ❑ Yes ❑ No Date: ______________

Stress test: ❑ Yes ❑ No Date: ______________

Carotid ultrasound: ❑ Yes ❑ No Date: ______________

Cardiac cath: ❑ Yes ❑ No Date: ______________