HEART CARE CENTER OF NW 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's Employer:** ____________

SECONDARY INSURANCE

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

Policy / ID #: ____________ **Group #:** ____________

Insured Name: ____________ SELF SPOUSE MOTHER FATHER **Insured BD:** ____/____/____

Insured SS#: ____________ **Insured's 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.

X ______________________________ ____/____/____
Patient's Signature Date

FEDERALLY MANDATED ELECTRONIC HEALTH RECORD
PATIENT DEMOGRAPHIC INFORMATION

Patient Name______________________________

Date or 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

E-Mail 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

9/2011

REQUEST FOR CONFIDENTIAL COMMUNICATION

This form is used to request alternate communication of confidential patient information. This form must be filled out completely and returned to our office. (PLEASE PRINT)

Patient Name: ____

Current Address: ____

City: ______________________ State: __________ Zip: ____________

Home Phone: ______________________ Cell: ______________________

Social Security Number: ______________________ Birth Date: ____________

Instructions per patient: ____

____

____

Persons to whom information may be disclosed:

____ Relationship: ____________

____ Relationship: ____________

____ Relationship: ____________

____ Relationship: ____________

____ Relationship: ____________

Patient Printed Name: ______________________________ Date: ____________

Patient's Signature: ______________________________ Date: ____________

Personal Representative Name: ______________________ Date: ____________

Representative's Signature: ______________________ Date: ____________

Acknowledgement of Notice of Privacy Practices

The Heart Care Center of Northwest Houston's Privacy Practice is available for review upon request.

I acknowledge that I have the right to review The Heart Care Center of Northwest Houston's Patient Privacy Practices. I am aware that The Heart Care Center of Northwest Houston will use and disclose my health information to any physician, pharmacy, hospital, insurance company and/or other healthcare provider that is necessary for treatment, payment and healthcare operations.

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. This form is available at the front desk, upon your request. This authorization is effective through lifetime unless revoked or terminated earlier by the patient or the patient's personal representative in writing.

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practices, but could not be obtained due to the following:

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

____

____

HEART CARE CENTER OF NORTHWEST HOUSTON, PA

Authorization for the Heart Care Center to Receive Protected Health Information from a Physician or Institution

Information regarding patient for whom authorization is made:
Full Name: ____________________
Other Name Used ____________________ Date of Birth ____________
Address ____________________ City ____________ State ________ Zip ________
Phone ________________ Email (Optional) ____________________

Please forward the requested health care information to:
Heart Care Center of Northwest Houston, PA
13325 Hargrave Road # 150
Houston, TX 77070
Phone: 281-955-7863 Fax: 281-955-8617

The person or entity who can release this information:
Name: ____________________
Address: ____________________ City ____________ State ______ Zip ________
Phone: ____________________ Fax ____________________

Specific Information to be disclosed:
____Medical Record from (insert date) ____________ to (insert date) ____________________
____ Entire Medical Record, including patient histories, office notes (except psychotherapy notes) test results, radiology studies, referrals, consults, billing records, insurance records and records received from other health professionals.
____ Other ____________________

Include: (Indicate by Initialing:
_____ Drug, Alcohol or Substance Abuse Records
_____Mental Health Records
_____HIV/AIDS Related Information (including HIV AIDS Test Results
_____ Genetic Information

Reason for release of Information: Choose all that apply)
_____ Treatment/Continuing Medical Care
_____ Personal Use
_____ Billing or Claims
_____ Insurance
_____ Legal Purposes
_____ School
_____ Employment
_____ Disability Determination
_____ Other

The individual signing this form agrees and acknowledges as follows:

Voluntary Authorization: This authorization is voluntary. Treatment, payment, will not be conditional upon my signing of this authorization form.

Effective Time Period: This authorization shall be in effect until Month: _______ Day: ________ Year: ______. (Or 2 years after the death of the patient for whom this authorization is made which ever date is earlier)

Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Special Information: This authorization may include disclosure of information relating to **drug, alcohol and substance abuse, mental health information** (except psychotherapy notes), **confidential HIV/AIDS-related information,** and **genetic information** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herin.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information tha has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and my no longer be protected by federal or state privacy laws.

Signatures:

Patient/Legal Representative ______________________________ Date: ____________

If Legal Representative, relationship to Patient: ______________________________

Witness (optional) ______________________________ Date: ____________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Minor's Signature (if applicable) ______________________________ Date: ____________

HEART CARE CENTER OF NORTHWEST HOUSTON

MUKARRAM A. BAIG, M.D., F.A.C.C., KAMRAN K. SHERWANI, M.D., F.A.C.C.
RUPIN A. KADAKIA, M.D., F.A.C.C., MOHAMMED S. KHAN, M.D., F.A.C.C., FAISAL A. ARAIN, M.D

NEW PATIENT QUESTIONAIRE

NAME:_________________________________ **DATE:**_________________________________

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

HOSPITAL FOLLOW UP FROM: ___North Cypress Hospital ___Methodist Willow brook ___Houston Northwest ___ Cy-Fair ___ St. Luke Vintage

CHIEF COMPLAINT (Reason for visit):____

PAST MEDICAL HISTORY (Illnesses or diseases) : **Please circle all that apply**

☐ CAD (heart disease/blockages)
☐ Valvular Heart Disease (heart murmur)
☐ Arrhythmias (irregular heart beat)
☐ 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 artery bypass)
☐ Mitral Valve
- ☐ Replacement
- ☐ Repair
- ☐ Bioprosthetic
- ☐ Mechanical

☐ PPM (pacemaker)
- ☐ Medtronic
- ☐ Guidant
- ☐ St. Jude
- ☐ Other:__________

☐ TIA (mini-stroke)
☐ Other:__________________
____
____

☐ Diabetes
- ☐ Type 1
- ☐ Type 2

☐ 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 heart disease Other:_____________________________________

SOCIAL HISTORY: ***Please fill in the blanks or circle as necessary***

Tobacco Use (smoking or chewing): Yes No Never Quit_____ yrs ago After_____ yrs of use PPD (packs/day)_____

Alcohol Use Yes No Number of drinks per week______ Recreational Drug Use Yes No

Occupation:____________________ Living Situation:____________________ Marital Status:__________

Exercise? Yes____________________ No Healthy eating habits? Yes No

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ALLERGIES: Medications ______________________________

____

Foods ______________________________

Environmental ______________________________

MEDICATIONS: **NAME** **DOSE** **FREQUENCY**

____

____

____

____

____

____

____

____

____

____

REVIEW OF SYMPTOMS ***(Symptoms you have been experiencing within the last 30 days):***

Please circle all that apply:

CV (Heart/Circulation): Chest Pain Palpitations Orthopnea (shortness of breath when lying flat) Edema (swelling) PND (shortness of breath that awakens you from sleep) Claudication (pain in legs when walking)

RESP (Lungs/Breathing): Shortness of breath Shortness of breath with exertion Cough Sputum Wheezing

CONST GENERAL: Fever Chills Fatigue (tired) Insomnia (trouble sleeping)

NEURO (Head): Memory Loss Confusion Syncope (fainting) Dizzy (Lightheaded) Numbness// Tingling Headache Seizures (Convulsions) Aphasia (difficulty speaking) Dysphasia (difficulty swallowing

EYES (Vision): Blurry Blind Double vision Glasses Contacts

EARS (Hearing): Hearing loss Hard of hearing Ringing in ears Pain in ears

GI (Digestion): Abdominal pain Weight Loss Weight Gain Constipation Diarrhea Nausea Vomitting Reflux / Indigestion (heart burn) Black Stools Bloody Stools Poor appetite

GU (Bladder) Pain Burning Frequency incontinence (accidents)

MS (Muscle/joints): Arthritis (joint pain) Backache Weakness Leg cramps (muscle spasms/ Charlie horses) Unsteady when walking

SKIN: Itching Rashes Bruises (easily) Sores/ Lesions Color change Diaphoresis (sweating)

PSYCH (Mental health): Anxiety (nervous) Depression Mood Swings Excessive Stress

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 ECG** (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 !!!!!