Health History Questioneer

Patient Name: _____ Current Date: ____/_____/_____

Social Security Number: _____-_____-_____ Date of Birth: ___/___/____ Sex: M/F

(Circle One) Married/Single/Divorced/Widow

Address: (Street) _____

(City)_____ (State) _____ (Zip) _____

Mailing Address (if different from above) _____

(City)_____ (State) _____ (Zip) _____

Email: _____ Pharmacy: _____

Home Phone Number: (____) _____-_____ Cell Phone Number: (____) _____-_____

Employment Status: Employed Retired Full Time Student Part Time Student Child Other

Employer Name: _____ Employer Phone Number: (____) _____-_____

Person responsible for bill (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____-____-_____

Relationship to Patient:: ( ) Spouse ( ) Parent ( ) Other Date of Birth: ____/_____/_____

Address: _____ Phone Number: : (____) ____-_____

Employer Name: _____

Person to call for an emergency:

Name: _____ Address:_____

Home Phone Number: (____) ____-_____ Work Phone: (____) ____-_____ Relationship: _____

Healthcare Proxy/Medical Power of Attorney (if not patient):

Name: _____ Address:_____

Home Phone Number: (____) ____-_____ Work Phone: (____) ____-_____ Relationship: _____

Please provide a copy of all insurance cards for our files.

Primary Insurance Information:

Insurance Carrier: _____ Effective Date: ____/_____/_____

ID: _____ Group Number: _____

Policyholder Name: _____ Date of Birth: ____/_____/_____ Sex: M F

Secondary Insurance Information:

Insurance Carrier: _____ Effective Date: ____/_____/_____

ID: _____ Group Number: _____

Policyholder Name: _____ Date of Birth: ____/_____/_____ Sex: M F

How did you hear about our practice? Advertisement Mailing Internet

Friend (name) _____

Other Provider (name) _____

Other _____

The HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). Individuals have the right to request receipt of confidential communications from us by alternative means or at alternative locations. You may change this information at any time by contacting our office.

I wish to be contacted in the following manner: (check all that apply)

- □ Phone
  - o Home phone
  - o Work Phone
  - o Cell Phone
  - o Leave message with detailed information
  - o Leave message with call back number only
- □ Fax (Fax Number: _____)
- □ Written Communication
  - o Mail to home address
  - o Mail to work address
- □ Email
- □ Text Message
- □ Other: (please specify) _____

The HIPAA Privacy Rule does not allow release of any information, including Health Information, Test Results, and Billing Information without your authorization. This includes your spouse or other family members. You may change this information at any time by contacting our office.

I authorize you to speak or correspondence with the following person(s) should they contact your office:

Name	Relationship	Regarding Health Information	Regarding Billing/Insurance information

I acknowledge that I have received a copy of the practice's Notice of Privacy Practices

CONSENT TO TREAT

The term “health care provider(s)” in this document means Southern Cardiovascular, PLLC, its agent and employees, members of the medical staff, their agents and employees and other health care practitioners who provide care to patients. I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for care including future treatment. I understand that this information serves as:

1. Basis for planning my treatment and care
2. Information used to file my claim with the insurance company (procedure and diagnosis)
3. Means by which a third-party payer can verify that billed services were actually provided
4. A tool for routine health care operations including assessing quality and reviewing competency of your staff and/or other health care providers

I understand that I have reviewed the Notice of Information Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing the consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing, and procedures as are deemed necessary in the course of my care.

RELEASE OF INFORMATION

Information about me necessary to substantiate my insurance claims may be release by the health care provider involved in my case.

FINANCIAL RESPONSIBILITY/ASSIGNEMENT OF BENEFITS

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health care providers are not paid after reasonable notice, that account shall be deemed delinquent and a service charge may be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

_____

(Signature) (Date)

_____

(Witness) (Title) (Date)

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized medical benefits be made either to me or on my behalf to Southern Cardiovascular, PLLC for any services furnished me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on item 9 of the CMS-1500 claim form or elsewhere on the approved claim form or electronically submitted claim, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and noncovered services. Co-insurance and deductible are based upon the charge determination of the Medicare Carrier.

_____

(Signature) (Date)

Health History Questioneer

Patient Name:_____Date of Birth:_____Current Date ____/_____/_____

Reason for Visit: _____

Do you current have (negative if not marked)

- □ Appetite Changes
- □ Bleeding disorder
- □ Chest Pain
- □ Edema
- □ Kidney Disease
- □ Leg Pain
- □ Muscle Cramps
- □ Non-healing or slow healing wounds
- □ Nausea
- □ Numbness/Tingling
- □ Orthopena (shortness of breath when lying down)
- □ Palpitations (heart racing/pounding)
- □ Shortness of breath
- □ Seizures
- □ Skin changes in feet or legs
- □ Syncope (fainting)
- □ Vertigo (dizziness)
- □ Vision Changes
- □ Weight Gain
- □ Weight Loss

When do your legs hurt? (circle all that apply) Never After walking 2 blocks or less When resting Always

What treatment have you tried to improve your leg symptoms in the last 6 months? (circle all that apply)

Elevate legs when at rest Antiplatelet or blood thinner therapy

Walking Other Exercise

Compression Stockings

Other: (please describe) _____

Did any of these help? Yes No Somewhat (please describe) _____

_____

_____

Allergies:

Substance	Severity	Reaction (ex: Rash, Nausea)
	Mild Moderate Severe	
	Mild Moderate Severe	
	Mild Moderate Severe	
	Mild Moderate Severe	

Has anyone in your family member been diagnosed with cardiovascular disease (heart attack, coronary artery disease, peripheral vascular disease, etc) _____ Yes _____ No

If yes, who? Mother
Father
Sister(s)
Brother(s)
Son(s)
Daughter(s)
Other _____

Have you had a flu shot in the last 12 months? Yes Date ____/_____/_____ No Refused

Have you ever had a pneumonia immunization? Yes Date ____/_____/_____ No Refused

Do you have:
Hypertension? _____ Yes _____ No
Kidney Disease? _____ Yes _____ No
Diabetes? _____ Yes _____ No
Liver Disease? _____Yes _____No

Have you ever used tobacco products? ____Never Smoked ____ Non-smoking tobacco user

____ Former Smoker/Tobacco user ___Current Smoker How much do you smoke? _____

Do you use street/illict drugs? No Yes Type _____

Do you eat healthy meals? No Yes

Surgical History: List any surgical procedures you have had:

____ Never had any surgical procedure

_____

_____

_____

_____

_____

Current Medications: Please include dosage (how many milligrams), frequency (how often you take it), and route (orally, injection, transdermal). Include all herbals, supplements, vitamins, and over the counter medication.

Do you take aspirin daily? Yes No

	Medication	Dosage	Frequency	Route
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				