TEXAS HEART & VEIN MULTISPECIALTY GROUP
HOUSTON CARDIOTHORACIC AND VEIN SURGEONS

Jon-Cecil Walkes, M.D. : Lamin Bangura, M.D. : Nathaniel Alabi, D.P.M : Akashdeep Singh, D.P.M.

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PATIENT DEMOGRAPHIC		
PCP:	**SEX :** Male OR Female	**RACE:** White / Black / Hispanic / Other
First Name:	**Middle Initial:**	**Last Name:**
DOB:	**SS #**	**Martial Status:**
Address:		
City:	**State:**	**Zip Code:**
Home #	**Cell #**	**Can we Leave a message? Y or N**

Email Address: _____

*Please Note we use Email for Medical Data Exchange Via Portal and for Communication with the patients IF WAIVER IS SIGNED

Employer:	**Occupation:**
Whom may we thank for referring you?	

EMERGENCY CONTACT	
Contact Name:	
Contact Phone:	**Relationship:**

PRIMARY INSURANCE		
INSURANCE NAME:		**Subscriber Name:** **Relationship to Patient:**
Insured's DOB:	**Insured's SS#**	**Insured's Phone #**
ID/ Member #		**Group #**

SECONDARY INSURANCE		
Subscriber Name:		**Relationship to Patient:**
Insured's DOB:	**Insured's SS#**	**Insured's Phone #**
ID/ Member #		**Group #**

ASSIGNMENT AND RELEASE TO INSURANCE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jon-Cecil Walkes, M.D., Lamin Bangura, M.D., or Nathaniel Alabi, D.P.M or insurance company to release any information required to process my claim.

_____ _____

Patient/ Guardian Signature Date

History Form

Name: _____ DOB: _____ Date: _____

Reason for Visit: _____

Smoke: Current Smoker? YES / NO Former Smoker? YES / NO Never Smoker? YES / NO

Alcohol: YES / NO if yes, How many drinks per week? _____

Recreational Drugs: YES/NO if yes, Drug Name(s) _____

Frequency: _____

FAMILY HISTORY

Mother: **Alive or Deceased** _____Diabetes _____Heart Disease _____Cancer
_____Hypertension _____Abdominal Aortic Aneurysm (AAA)

Father: **Alive or Deceased** _____Diabetes _____Heart Disease _____Cancer
_____Hypertension _____Abdominal Aortic Aneurysm (AAA)

SYMPTOMS

LIST YOUR SYMPTOMS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

ALLERGIES? YES OR NO (PLEASE CIRCLE**)**

IF YES PLEASE LIST:

_____

PHARMACY INFORMATION

PHARMACY NAME: _____

ADDRESS: _____ **CITY:** _____**STATE:** _____

ZIP: _____ **PHONE #** _____ **FAX #** _____

HISTORY

___Diabetic

___Hypertension (high blood pressure)

___Hyperthyroid

___Coronary Artery Disease

___ Angina

___High Cholesterol

___ Ulcers/ Wounds Lower Extremity

___ Leg Edema

___ Heart Failure

___ Asthma

___ GERD

___ Cardiomyopathy

Other Medical History

_____

SURGERY HISTORY

***Please list with Date**

1. _____DATE: _____
2. _____DATE: _____
3. _____DATE: _____
4. _____DATE: _____
5. _____DATE: _____

MEDICATIONS

Name: _____ Dose/Frequency:_____

Name: _____ Dose/Frequency:_____

Name: _____ Dose/Frequency:_____

Name: _____ Dose/Frequency:_____

Name: _____ Dose/Frequency:_____

Name: _____ Dose/Frequency:_____

Name: _____ Dose/Frequency:_____

Name: _____ Dose/Frequency:_____

Patient Signature: _____ Date: _____

UNENCRYPTED EMAIL COMMUNICATION

Patient Request for Unencrypted Email Communication

Patient Name: _____ **Date of Birth: _____**

Phone Number: _____ **Email Address:_____**

This form authorizes Texas Heart and Vein Multispecialty Group to communicate with you via unencrypted email.

I understand that communication over the internet or use of an email system may not be secure and there is no assurance of confidentially when communicating via unencrypted email.

Please be advised that:

- **This request applies only to Texas Heart and Vein and provider stated below. A separate form is required if you would like to request to communicate via unencrypted email with another healthcare provider.**
- An email address must be provided
- A test email is recommended before corresponding via email.

I understand and agree to the following:

- The email address provided is accurate and I accept responsibility for messages sent to or from this email address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PATIENT EMAIL form. Communication over the internet or using unencrypted email may not be secure and there is no assurance of confidentiality of information communicated via unencrypted email.
- Email communication may be forwarded to other providers and documented in my medical record for my treatment.
- I have the right at any time to revoke this authorization by contacting my provider and informing them that I wish to revoke my authorization.
- I agree to hold Texas Heart and Vein Multispecialty Group and individuals associated with Texas Heart and Vein harmless from any and all claims and liabilities arising from or related to this request to communicate via unencrypted email.

_____ _____

Signature of Patient Date

HIPPA / AUTHORIZATION FORM
For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name: _____DOB: _____

The health information you may release subject to this authorization is as follows: **(Check all that applies)**

_____Complete Medical Records _____Radiology Reports

_____Consultation/ Progress Notes _____Labs

_____Speak to Over Phone _____All the above

OR

_____I DO NOT GIVE PERMISSION FOR YOU TO RELEASE MY INFORMATION TO ANYONE.

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name of Patient or Authorized Representative Date

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Available Copies in the Lobby and Exam Rooms

Date: _____

I acknowledge that I was provided with a copy of the HIPPA / Notice of Privacy Practices.

Patient Name (Print): _____

Patient (Signature): _____

If completed by a patient's personal representative (or if the patient is a minor), please print and sign your name in the space below.

Personal Representative/Guardian (Print):

_____

Personal Representative/Guardian (Signature):

_____

Relationship to the patient: _____

CONTINUE TO NEXT PAGE

AUTHORIZATION FOR AND RELEASE OF PATIENT PHOTOGRAPHS

This is a consent document discussing your permission to take photographs and to use these images for the purpose defined below. It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by Texas Heart and Vein Multispecialty Group.

CONSENT TO TAKE PHOTOGRAPHS

I, _____ hereby authorize Texas Heart and Vein Multispecialty Group, **(patient's name or guardian)** its successors and assigns, the right to take preoperative, intraoperative, and postoperative photographs of me.

CONSENT FOR RELEASE OF PHOTOGRAPHS

I,_____ hereby authorize Texas Heart and Vein Multispecialty Group, **(patient's name or guardian)** its successors and assigns, the right to use preoperative, intraoperative, and postoperative photographs of me in which I have participated on behalf of Texas Heart and Vein. The usage of these photos will be limited to: medical purposes related to case scientific purposes, including seminars and medical articles before and after photo album for other patients to view in the office before and after photos to be included in newsletter to be sent to patients before and after photos to be included in Texas Heart and Vein web site

Texas Heart and Vein Multispecialty Group need not approach me again for authorization to use these photos unless the usage differs from that listed above.

Neither, I nor any member of my family will be identified in any publication. I understand that in some circumstances the photos may portray features that may make my identity recognizable. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

This release and authorization do not conflict with any existing commitment on my part. I understand that Texas Heart and Vein is not obligated to make use of its rights set forth herein.

Patient Name (Print): _____

Patient (Signature): _____ DATE: _____

Patient Address: _____

City: _____ State:_____ Zip: _____

Patient Phone # _____