HEART CARE OF CONROE
600 River Pointe Drive, Suite 100 Conroe Tx, 77304
Ph# (936) 525-3512 Fax# (936) 525-2936

PATIENT INFORMATION FORM

WHO IS YOUR PRIMARY/FAMILY/REFERRING DOCTOR? _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE INIT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL: _____ WORK: _____ EXT: _____

SEX: MALE / FEMALE D.O.B: _____ SOC SEC # _____-_____-_____

___ STUDENT ___ RETIRED ___ EMPLOYED WHERE: _____

MARITAL STATUS: _____

SPOUSE NAME: _____ D.O.B: _____ SOC SEC # _____-_____-_____

SPOUSE EMPLOYER: _____ SPOUSE WORK #: _____ CELL: _____

LOCAL PHARMACY: _____ LOCAL PHARMACY PHONE: _____

MAIL ORDER PHARMACY: _____ MAIL ORDER PHARMACY #: _____

E-MAIL ADDRESS: _____

PRIMARY INSURANCE: _____ PHONE: _____

CLAIM ADDRESS: _____

ID #: _____ GROUP #: _____

INSURED NAME: _____ D.O.B: _____

SECONDARY INSURANCE: _____ PHONE: _____

CLAIM ADDRESS: _____

ID #: _____ GROUP #: _____

INSURED NAME: _____ D.O.B: _____

PATIENT'S PERSONAL HISTORY

Patient Health History Form

Name: _____ **Date:** _____
SSN: _____ **DOB:** _____

Chief Complaint: What is the reason for your visit today (please describe problem in detail): _____

_____

_____

_____

Past Medical History: Please check all that apply to you:

- ❑ Arthritis
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy/seizures
- ❑ Heart problems
- ❑ Heart surgery
- ❑ High blood pressure
- ❑ Psychiatric disease
- ❑ Stroke
- ❑ Thyroid
- ❑ None

Previous Surgeries: Please list past surgeries with approximate date: _____

_____

_____

_____

Serious Injury: Please describe any serious injuries you have had: _____

_____

Medications: Please list any medications you are taking with dose and frequency:

Drug	*Dose/Frequency*

Allergies: please list any allergies that you have _____

_____

Do you drink alcohol? ❑Yes ❑No If yes, how much/week? _____
Do you smoke? ❑Yes ❑No If yes, how many cigarettes/day? _____
Do you consume caffeine? ❑Yes ❑No If yes, how many cups/week? _____
Do you use recreation drugs? ❑Yes ❑No If yes, what type and frequency? _____
Are you on a special diet? ❑Yes ❑No If yes, please describe? _____

Family History: Do you know of any blood relative who has or had:

- ❑ Asthma
- ❑ Aneurysm
- ❑ Brain Tumor
- ❑ Cancer, Type:
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Headaches
- ❑ Heart Problems
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Lung Disease
- ❑ Migraine
- ❑ Multiple Sclerosis
- ❑ Psychiatric Disease
- ❑ Stroke
- ❑ Thyroid
- ❑ None

Comments:

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Authorization for Release of Medical Records To:

By signing this form, I *_____ authorize **Heart Care Of Conroe** to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the **person(s) or entity** listed below.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Initial:_____ Date:_____

Limitations on the information you may release subject to this Release Form are as follows:

_____

_____

***Release my protected health information to the following person(s)/entity:**

Name: _____

Street:_____

City:_____ **State:**_____ **Zip Code:**_____

The reasons or purpose for this release of information are as follows:

_____

_____

_____

Patient Signature (or parent, guardian or legal representative):

***** _____ **Date:**_____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Patient Health History Form

As you review the following list, please check any problems or conditions, that you are experiencing or have experienced. If you do not have any of the problems listed in the section please check none.

General Health
- ❑ Good general health
- ❑ Recent weight change
- ❑ Loss of appetite
- ❑ Fatigue
- ❑ Fever/chills

Allergy
- ❑ Drug allergies
- ❑ Food allergies
- ❑ Hay fever
- ❑ Other: _____
- ❑ None

Ears, Nose, Mouth, Throat
- ❑ Difficulty swallowing
- ❑ Earaches
- ❑ Loss of hearing/deafness
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Painful chewing
- ❑ Ringing in ears
- ❑ Sinus infection
- ❑ Sores in mouth
- ❑ None
- ❑ Other: _____

Eyes
- ❑ Blind spots
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
- ❑ Glaucoma
- ❑ Injury
- ❑ Pain
- ❑ Other: _____
- ❑ None

Gastrointestinal
- ❑ Blood in stools
- ❑ Increasing constipation
- ❑ Nausea
- ❑ Painful bowel movements
- ❑ Persistent diarrhea
- ❑ Stomach or abdominal pain
- ❑ Ulcer
- ❑ Vomiting
- ❑ Other: _____
- ❑ None

Genitourinary
- ❑ Blood in urine
- ❑ Female: irregular periods
- ❑ Female: #pregnancies_____ #miscarriages_____
- ❑ Female: vaginal discharge
- ❑ Kidney stones
- ❑ Male: prostate disease
- ❑ Male: testicle pain
- ❑ Painful or burning urination
- ❑ Sexual difficulty
- ❑ Sexually transmitted disease
- ❑ Urgency with urination
- ❑ Urine retention/ incontinence
- ❑ Other: _____
- ❑ None

Heart and Lungs
- ❑ Pain in chest
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beat
- ❑ Other: _____
- ❑ None

Muscles/Joints/Bones
- ❑ Back pain
- ❑ Difficulty walking
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Muscle pain or tenderness
- ❑ Neck pain
- ❑ None

Neurological
- ❑ Balance trouble
- ❑ Black outs/loss of consciousness
- ❑ Difficulty speaking
- ❑ Difficulty walking
- ❑ Facial drooping
- ❑ Headaches
- ❑ Injury to the brain or spine
- ❑ Light-headed or dizziness
- ❑ Memory loss
- ❑ Mental Confusion
- ❑ Migraines
- ❑ Mini stroke
- ❑ Neuropathy
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Stroke
- ❑ Tremors
- ❑ Weakness
- ❑ Other: _____
- ❑ None

Are you? ❑ right handed ❑ left handed ❑ Both

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Eating disorder
- ❑ Other: _____
- ❑ None

Pulmonary
- ❑ Asthma
- ❑ Blood in cough
- ❑ Cancer
- ❑ Chronic or frequent cough
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Other: _____
- ❑ None

Skin
- ❑ Rash or itching
- ❑ Sun sensitivity
- ❑ Hair loss
- ❑ Color changes
- ❑ Other: _____
- ❑ None

Sleep
- ❑ Snoring
- ❑ Sleepwalking
- ❑ Nightmares

Do you sleep well? ❑Yes ❑No
Do you feel rested when you wake? ❑Yes ❑No
Do you fall asleep during the day? ❑Yes ❑No

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Authorization Form for Release of Protected Health Information

Patient Name: _____ *May we leave messages in your voicemail? ☐ Yes or ☐ No

Below please list any family member or Physician we may share your medical information with:
Release my protected health information to the following person(s)/entity:

Name: _____ Phone: _____
Street: _____ City:_____ State:_____ Zip: _____

Name: _____ Phone: _____
Street: _____ City:_____ State:_____ Zip: _____

This authorization shall be in force and effective until the following event and/or date: _____
_____

The reasons or purposes for this release of information are as follows:

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice: Dr Alan Mobley

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Signature of Patient or Personal Representative _____ Date_____
Name of Patient or Personal Representative _____ Description of Personal Representative's Authority
By signing this form, I authorize you to use and disclose the protected health information described below

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority

For Office Staff Use Only:
If the patient refuses to sign a written acknowledgement of the Notice of Privacy Practice, please indicate your comments:
_____
Name: _____ Date: _____

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Authorization for Release of Medical Records from another Facility to HCC

NAME_____D.O.B:_____
SOC SEC#_____

I hereby authorize the release of information contained in my medical records to:

Alan Mobley, M.D, F.A.C.C

(936) 525-3512 PHONE (936) 525-2936 FAX (Conroe)

_____ All Medical Records
_____ Cardiac Testing
_____ EKG
_____ Recent Labs
_____ Recent Progress Notes

*The information being released will be used for medical purposes.
*The authorization is valid for one year from the date of signing.
*The patient of his/her representative may revoke this consent at any time.

_____	_____	_____
Printed Name	Signature	Date

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MEDICARE AND COMMERCIAL INSURANCE SIGNATURE ON FILE

I hereby request that payment of authorized Commercial Insurance and/or Medicare benefits be made on my behalf to Dr. Alan Mobley for any services furnished me by the company listed. I authorize any holder of Medical Information about me to release to Medicare and/or Commercial Insurance and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature below requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determined of the Medicare Carrier as full charge, and the patient is responsible for only the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Commercial Insurance and/or Medicare Carrier.

Patient's Printed Name: _____

Patient's Signature:_____ Date:_____