PATIENT INFORMATION/ INFORMACION DE PACIENTE

Patient's Last Name/Aoellido:	First/Primer Nombre:	Middle/ Inicial:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status/ Estado Civil Soltero/Casado/Divorciado/Viudo Single / Mar / Div / Sep / Wid

Ethnicity/ Etnicidad : ❑ Declined/ Declinar ❑ Hispanic or Latino/ Hispano o Latino ❑ Non-Hispanic or Latino/ No hispano o latino ❑ Unknown/desconocido	Race : ❑ Declined/ Declinar ❑ American Indian / Alaska Native/ Indio Americano ❑ Asian/Asiatico ❑ White/ Raza Blanca ❑ Black or African American ❑ Native Hawaiian or Pacific Islander/ Hawaiano Nativo ❑ Other/ Otro ❑ Unknown/ Desconocido	Social Security #/ # de Seguro Social:	Birth date/ Fecha De Nacimiento: / /	Age/ Edad:	Sex/ Sexo: ❑ M ❑ F

Primary Language Spoken/ Primer Idioma: ______________________	Secondary Language/ Segundo Idioma: ______________________

Street Address/ Direccion:	Home Phone #/ # De Telefono: ( )	Cell #/ # de Cellular: ( )

City/ Ciudad:	State/ Estado:	Zip Code/ Codigo Postal:	Email address/ Direccion de correo electonico:

Occupation/ Occupacion:	Employer/ Empleador:	Work Phone #/ # de telefono de trabajo: ( )

Referred to clinic by/ Referrido ala clinica por: (please check one box/ marque uno)	❑ Dr.	❑ Insurance Plan/ Seguro Medico	❑ Hospital

❑ Family/ Familia	❑ Friend/ Amigo	❑ Close to home/work/ Cerca de hogar o trabajo	❑ Yellow Pages/ Paginas Amarillas	❑ Other/ Otro

Other family members seen here:
Otros familiares que son pacientes aqui:

INSURANCE INFORMATION/INFORMACIÓN DEL SEGURO

Primary Insurance Carrier/ Seguro Primario:	Who is the insured?/ Quien es el Asegurado?:	Relationship to the Insured/ Relacion a asegurado:
Member ID #/ # de ID del Miembro:	Group Number/ Numero de Grupo:	Birth Date/ Fecha de nacimiento:
Secondary Insurance Carrier/ Seguro Secundario:	Who is the insured?/ Quien es el Asegurado?:	Relationship to the Insured/ Relacion a asegurado:
Member ID #/# de ID del Miembro:	Group Number/ Numero de grupo:	Birth Date/ Fecha De nacimiento:

GUARANTOR / RESPONSIBLE PARTY/ GARANTE/ PERSONA RESPONSABLE

Name and address/ Nombre y Direccion:	DOB/ Fecha de Nacimiento: SS#:	Home Phone # de telefono: Work Phone/# de trabajo:

IN CASE OF EMERGENCY/ EN CASO DE EMERGENCIA

Name of friend or relative/ Nombre de familiar o Amigo:	Relationship to patient/ Relacion al pacientet:	Home Phone/ # de telefono: Work Phone/ # de trabajo:

This information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **CorCareTX** or insurance company to release any information required to process my claims/ Esta información es verdadera a lo mejor de mi conocimiento. Autorizo a mis beneficios de seguro a pagar directamente al doctor. Entiendo que soy financieramente responsable de cualquier balance. También autorizo **CorCareTX** or mi compañía de seguros para liberar toda la información necesaria para procesar mis reclamos.

Patient/Guardian Signature/
Firma De Paciente/o guardian:

Date/ Fecha:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME/ NOMBRE (Last, First, M.I.):	☐ M ☐ F	**DOB/ FECHA DE NACIMIENTO :**
MARITAL STATUS ESTADO CIVIL:	☐ Single/ Soltero ☐ Partnered/ Con pareja ☐ Married/ Casado ☐ Separated/ Separado ☐ Divorced/ Divorciado ☐ Widowed/ Viudo	
PREVIOUS OR REFERRING DOCTOR/ MEDICO ANTERIOR/ O MEDICO DE REFERENCIA:		**DATE OF LAST PHYSICAL EXAM/ FECHA DE ULTIMO EXAMEN FISICO :**

RESONS FOR YOUR VISIT/ RAZON' DE SU VISTIA

INDICATE ALL REASONS INDICAR POR TODAS LAS RAZONES	☐ Chest pain ☐ Shortness of Breath ☐ Palpitations ☐ Racing heart ☐ Swelling legs ☐ Dizziness/fainting	
	☐ Hypertension	☐ Establish new cardiologist
	☐ Heart Failure	☐ Irregular heart rate
	☐ Pre Surgical Evaluation	☐ Other

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED/ LISTA DE PROBLEMAS MÉDICO QUE OTROS MÉDICOS LO HA DIAGNOSTICADO

SURGERIES/ CIRUGÍAS

Year/ Año	Reason/ Razón	Hospital

OTHER HOSPITALIZATIONS/ OTROS HOSPITALIZACIONES

Year/ Año	Reason/ Razón	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION? / HA TENIDO UNA TRANSFUSIÓN DE SANGRE? IF ***YES***, WHEN?/ SI, CUANDO? How many?/ Cuantas? :	☐ Yes/ Si	☐ No

LIST YOUR PRESCRIBED MEDICATIONS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS/ LISTA DE SUS MEDICAMENTOS CON RECETA Y MEDICAMENTOS DE VENTA LIBRE, COMO LAS VITAMINAS Y LOS INHALADORES		
Name the Drug/ Nombre de Medicina	Strength/ Fuerza de medicina	Frequency Taken/ Que tan seguido se toma

ALLERGIES TO MEDICATIONS/ ALERGIAS A MEDICAMENTOS	
Name the Drug/ Nombre de medicina	Reaction You Had/ Reacción que tuvo

HEALTH HABITS AND PERSONAL SAFETY/ HÁBITOS DE SALUD Y SEGURIDAD PERSONAL

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. TODAS LAS PREGUNTAS CONTENIDAS EN ESTE CUESTIONARIO SON OPCIONALES Y SE MANTENDRÁ ESTRICTAMENTE CONFIDENCIAL.	
Exercise/ Ejercicio	☐ Sedentary (No exercise)/ No Ejercicio
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)/ Ejercicio Suave (i.e caminar, subir escaleras, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)/ ejercicio vigoroso ocasional (i.e menos de 4 veces por 30 minutos)

	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)/ Ejercicio vigoroso regularmente (4 veces o mas ala semana por 30 minutos o mas)			
Diet/ Dieta	Are you dieting?/ Esta en dieta?		☐ Yes/ Si	☐ No
	If yes, are you on a physician prescribed medical diet?/ Si, esta prescrito por un doctor?		☐ Yes/ Si	☐ No
	# of meals you eat in an average day?/promedio cuantas comidas come por dia?			
	Rank salt intake/ Cuanto sal come	☐ Hi/ Alto	☐ Med/ Mediano	☐ Low/ bajo
	Rank fat intake/ cuanta grasa come	☐ Hi/ alto	☐ Med/ mediano	☐ Low/ bajo
Caffeine/ Cafeina	☐ None/ nada	☐ Coffee/ café	☐ Tea/ té	☐ Cola
	# of cups/cans per day?/ numero de tazas/ latas por dia?			
Alcohol	Do you drink alcohol?/ Tomas alcohol?		☐ Yes/ Si	☐ No
	If yes, what kind?/ Si, que tipo de alcohol?			
	How many drinks per week?/ Cuanta bebidas por semana?			
	Are you concerned about the amount you drink?/ Está preocupado por la cantidad que bebe?		☐ Yes/ Si	☐ No
	Have you considered stopping?/ Has pensado en parar de beber?		☐ Yes/ Si	☐ No
	Have you ever experienced blackouts?/ Ha tenido pérdida del conocimiento ?		☐ Yes/ Si	☐ No
	Are you prone to “binge” drinking?/ Es usted propenso a la borrachera?		☐ Yes/ Si	☐ No
	Do you drive after drinking? /Maneja despues de tomar?		☐ Yes/ Si	☐ No
Tobacco/ Tabaco	Do you use tobacco?/ Usa Tabaco?		☐ Yes/ Si	☐ No
	☐ Cigarettes – pks./day/ Cigarrillos-cuantos/dia	☐ Chew - #/day/ masticar- cuanto/dia	☐ Pipe - #/day/ Pipa-cuanto/ dia	☐ Cigars - #/day/ cigarros-cuanto/dia
	☐ # of years/ # de años de uso	☐ Or year quit/ que año dejo de usar Tabaco?		
Drugs/ Drogas	Do you currently use recreational or street drugs?/ Utiliza drogas recreativas o de la calle?		☐ Yes/ Si	☐ No
	Have you ever given yourself street drugs with a needle?/ Alguna vez te has dado drogas de la calle con una aguja?		☐ Yes/ Si	☐ No

Prior Heart Disease & Testing	Heart murmur/ valve prolapse?	☐ Yes/ Si	☐ No
	Rheumatic/Scarlet fever? Fiebre escarlata reumática	☐ Yes/ Si	☐ No

	Angina/Chest Pain? Dolor en el pecho de Angina?	☐ Yes/ Si	☐ No
	Heart Cath/ Angioplasty / Stent? Stent de angioplastia de catéter cardíaco	☐ Yes/ Si	☐ No
	Bypass Surgery/Pacemaker ?	☐ Yes/ Si	☐ No
	Defibrillator? Desfibrilador	☐ Yes/ Si	☐ No
	Heart Failure? insuficiencia cardíaca	☐ Yes/ Si	☐ No
	Stress test (treadmill) or Echo/ Ultrasound	☐ Yes/ Si	☐ No
	Calcium Scoring or Nuclear Thallium PET Scan	☐ Yes/ Si	☐ No
	Carotid Ultrasound – CT Angiogram or Holter (24hr monitor)	☐ Yes/ Si	☐ No

FAMILY HEALTH HISTORY/ HISTORIA DE FAMILIA

	AGE/ EDAD	SIGNIFICANT HEALTH PROBLEMS/ PROBLEMAS DE SALUD		AGE/ EDAD	SIGNIFICANT HEALTH PROBLEMS/ PROBLEMAS DE SALUD
FATHER/ PADRE			Children/ Hijos	☐ M ☐ F	
MOTHER/ MADRE				☐ M ☐ F	
Sibling/ Hermanos	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDMOTHER** Maternal/ **Abuela Materna**		
	☐ M ☐ F		**GRANDFATHER** Maternal / **Abuelo Materna**		
	☐ M ☐ F		**GRANDMOTHER** Paternal/ **Abuela Paterno**		
	☐ M ☐ F		**GRANDFATHER** Paternal **Abuelo Paterno**		

MENTAL HEALTH/ SALUD MENTAL

Is stress a major problem for you?/ Estrés es problema para ústed?	☐ Yes/ Si	☐ No
Do you feel depressed?/ Se siente deprimido?	☐ Yes/ Si	☐ No
Do you panic when stressed? / no entrar en pánico cuando está estresado?	☐ Yes/ Si	☐ No
Do you have problems with eating or your appetite? / Tiene problemas con comer or apetito?	☐ Yes/ Si	☐ No
Do you cry frequently? / llora frequentemente?	☐ Yes/ Si	☐ No
Have you ever attempted suicide? / Alguna vez ha intentado suicidarse?	☐ Yes/ Si	☐ No
Have you ever seriously thought about hurting yourself?/ Alguna vez ha pensado seriamente en hacerse daño?	☐ Yes/ Si	☐ No
Do you have trouble sleeping?/ Tiene dificultad para dormir?	☐ Yes/ Si	☐ No
Have you ever been to a counselor?/ Alguna vez has visto a un consejero?	☐ Yes/ Si	☐ No

CorCareTx

NOTES

NOTES

RISK FACTOR/HEART & BLOOD VESSEL DISEASE/ ENFERMEDAD CARDIACA

High Cholesterol? colesterol alto	☐ Yes/ Si	☐ No
High Blood pressure? presión arterial alta		
Phen/Fen weight loss medicine?	☐ Yes/ Si	☐ No
Diabetes?	☐ Yes/ Si	☐ No
Carotid Disease or endarterectomy?	☐ Yes/ Si	☐ No
Stroke or TIA (ministroke)?	☐ Yes/ Si	☐ No
Aortic Aneurysm?	☐ Yes/ Si	☐ No
Numbness or tingling of legs?	☐ Yes/ Si	☐ No
Leg cramps while walking?	☐ Yes/ Si	☐ No
Venous thrombosis (Leg Clots)? coágulos de las piernas	☐ Yes/ Si	☐ No

Pulmonary embolism (Lung Clots) ? coágulos pulmonares	☐ Yes/ Si	☐ No

OTHER PROBLEMS/ OTROS PROBLEMAS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.
Compruebe si usted tiene, o ha tenido algún síntoma en las siguientes áreas de un grado significativo y explicar brevemente.

☐ Skin/ Piel	☐ Chest/Heart/ pecho/ corazon	☐ Recent changes in/ cambios recientes en:
☐ Head/Neck/ Cabeza y Cuello	☐ Back/ espalda	☐ Weight/ peso
☐ Ears/ oídos	☐ Intestinal/	☐ Energy level/ nivel de energía
☐ Nose/ nariz	☐ Bladder/ vejiga	☐ Ability to sleep/ Capacidad para dormir
☐ Throat/ garganta	☐ Bowel/ intestino	☐ Other pain/discomfort/ otros Dolores o molestias:
☐ Lungs/ pulmones	☐ Circulation/ circulación	

PATIENT CONSENT

Initial

_______ CONSENT TO MEDICAL CARE AND TREATMENT
I am being treated at ("Physician Office/Clinic"), and I consent to all medical and surgical care, examinations and tests determined by my Physician that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physician's recommendations as they may relate to my health that the Physician and this Office will not be responsible for any injuries or damages that are a result of my non-compliance. If you have any concerns regarding any test or treatment recommend by your provider, we encourage you to ask questions.

_______ CONSENT TO PHOTOGRAPH, VIDEOTAPE OR RECORD
I authorize Physician Office to photograph, videotape or record me and agree that the negatives, slides, prints or tapes may be used for medical reasons (including training, education and/or research). I hereby release Physician Office, its employees, physicians and other authorized persons, from any responsibility or liability which might arise from the taking and authorized use of negatives, slides, prints and/or tapes.

_______ CONSENT TO USE OF INFORMATION
Electronic Health Records. I understand that the Physician Office may collaborate with other health care providers to coordinate, manage and provide health care to me and I consent to the Physician Office's sharing my health information and records electronically for the purpose of treatment, payment and/or operations, including the overall quality health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health record (EHR) will be accessible by CorCareTX credentialed physician practices as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations and or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). The Physician Office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information. In addition to the above consent to use and share my health information with the CorCareTX EHR system, I agree that the Physician Office may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement

activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health oversight services.

Request for Information from Others. **I consent to the Physician Office's request of my health information from other providers providing care to me, receipt of and release of my health information, whether written, verbal or electronic, for the uses described above as well as by the Physician Office's participation in any health information exchange described in the Physician Office's Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.**

_______ ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of Physician Office's Notice of Privacy Practices which provides information on how the physician office may use or disclose PHI for purposes of treatment, payment, and/or health care operations, including consent for calls regarding payment/collections on any phone number provided.

_______ ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physician Office for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

_______ FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided and/or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary, but are later determined unnecessary by the payer.

_______ PHARMACY BENEFITS MANAGERS

I understand and agree that CorCareTX, Dr Brian Eades can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

_______ PERSONAL VALUABLES

I understand that the Physician Office does not accept responsibility for any lost, stolen and/or damaged personal items while I am at the Physician Office.

________ OFFICE POLICIES

As a patient of Dr Brian Eades I understand that the following policies are currently in effect:

A $30.00 fee will be assessed on all returned checks. Returned checks will have to be paid in cash within 10 days of notification. I also understand if outstanding check is not resolved within the 10 day limit I may be dismissed from the practice. A $25.00 may be applied to my account for any missed appointments I do not cancel more than 24 hours in advance. I also understand this fee, if assessed, must be paid prior to my next visit with CorCareTX. I understand payment is due at time services are rendered, unless prior payment arrangements are made with the office. This includes any deductible, copayment or co-insurance amounts. Any balances not paid by my insurance carrier are my responsibility to resolve. I further understand that balances due must be paid in a timely manner to avoid further collection action. I understand if my account is forwarded to a collection agency I may be dismissed from the practice, my outstanding balance may be reported to the credit bureau and my balance may be charged an 18% interest rate per year until balance is resolved. I am to present proof of my insurance coverage at *every* office visit. I understand if I am more than 15 minutes late for my scheduled appointment I *may* be asked to reschedule for another day. Finally, I understand that I am to allow at least 48 hours for my prescription refills.

Initial

________ ACCESS TO ONLINE COMMUNICATIONS (PATIENT PORTAL)

Online communications do not decrease or diminish any of the other ways in which you can communicate with your provider. It is an additional option and not a replacement. The Practice may stop providing online communications with you or change the services provided online at any time without prior notification to you.
I acknowledge that I have received or been offered a copy of the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All of my questions have been answered and I understand and concur with the information.

Patient Name: ______________________________ ***Patient Date of Birth:*** ____________________

Patient Address/City/State/Zip Code

____ ____________________

_______________________________________ ____________ ________________.
Patient or Legal Representative Signature ***Date of Signature*** ***Relationship of Legal Representative to Patient***

RELEASE OF INFORMATION

I give my permission for the office staff to leave a message on my answering machine regarding:

_____Appointment reminders _____Test results

_____Requests for return phone call _____No answering machine available or permission not given

I give my permission for the office staff to speak to:

PERSON	RELATIONSHIP	PHONE NUMBER

Regarding:

____Appointment times **____Any changes in my treatment**

____My medical condition **____Need to return call to Clinic**

____**My test results** ____**Other, please specify:**______________

I give my permission for the office staff to contact me at my place of employment if absolutely necessary:

____Permission given ____Permission denied

I give my permission for the following person to pick up my prescriptions/medications::

PERSON	RELATIONSHIP	PHONE NUMBER
___________________________________	___________________	_________________
____________________________________	___________________	_________________

____ ______________________

Patient Signature/Date of Birth **Date**

____ ______________________

Witness **Date**