NEW PATIENT INFORMATION

Last Name	First Name, Middle	Social Security Number	Sex	Date of Birth	Marital Status

Race	Ethnicity	Language

Street Address	City	State	Zip	Country

Home Tel. No.	Work/DaytimeTel. No.	Mobile/Cell Tel. No.	Email Address

Referring Physician Name	Physician Phone No.	PCP	PCP Phone No.

Patients Employer (If retired please indicate company name)	Employers Contact

Employers Street Address	City	State	Zip

Emergency Contact	Relationship	Emergency Tel. No.

Who Referred Patient:

☐ Physician ☐ Self ☐ Friend ____________________ ☐ Other Patient ____________________ ☐ Tel. Directory ☐ Website

☐ Internet ☐ Advertisement ____________________ ☐ Insurance Carrier ☐ Other __________________________

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage unless other arrangements have been made.

Insurance Authorization and Assignment:

I hereby authorize any physician who has treated or attended me or my dependant to furnish information concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical/surgical services rendered to myself or my dependant. I understand that I am responsible for any amount not covered by insurance. I know that I have a right to recieve a copy of thisauthorization. I agree a photographic copy is as valid as the original.

Signature: ________________________________ Date: ________________________________

Authorization To Release Private Health Information

In the event you must be contacted by telephone with regards to test results, referrals, appointments, medical or billing information, please let us know how you prefer that we contact you by marking one or all of the following that may apply:

☐ Leave a recorded, detailed message on machine at preferred number (   ) ________________

☐ Do not leave detailed message.

You May Discuss Any of My Medical/Billing Information With The Following Contacts

Name ________________________ Day Time Phone ____________________________ Evening Phone __________________________

Relationship/Comments ____

Name ________________________ Day Time Phone ____________________________ Evening Phone __________________________

Relationship/Comments ____

Preferred Pharmacy Name & Phone Number: ____

Pharmacy Address or Cross Street: ____

Signature: ____ Date: ________________________________

________________________________ ________________________________ ________________

Print Legal Guardian Name | Legal Guardian Signature | Date

MEDICAL HISTORY FORM

Patient Last Name:____________________ First:____________________ Middle Initial:________

Date of Birth:____________________ Age:__________ Male ☐ Female ☐ Today's Date:____________________

Who Referred You? Name of Doctor:____

To Be Completed By Patient

Reason for your visit today:____________________

Indicate current or new problems and briefly explain:

- ☐ Recent Hospitalization: ____________________
- ☐ Decreased exercise tolerance: ____________________
- ☐ Lower extremity swelling/edema: ____________________
- ☐ Chest Pain ____________________
- ☐ Dizziness: ____________________
- ☐ Shortness of Breath: ____________________
- ☐ Syncope (Fainting): ____________________
- ☐ Other: ____________________

Physician's Comments - (ROS/HPI)

Are you allergic to any drug(s)? ☐ No ☐ Yes if yes, please list drug(s):____________________

List All Current Medication(S) (Drugs, Pills, Strength, And How Often Taken

☐ Refer to Medication List

List All Previous Surgeries And Dates

Social History

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widow/Widower Who lives with you? ____________________

Current Occupation/Employer:____________________ What Kind of Work?____________________

Do You Smoke? ☐ Yes ☐ No If yes, how many packs/day?_______ How Many Years?__________ Quit? ☐ Yes ☐ No When?__________

Do you drink alcohol? ☐ Yes ☐ No

Immunizations

Health Status of Blood Relatives:
Check all that apply and indicate which family member(s):

- ☐ History of heart disease (heart attack, heart failure)?
- ☐ History of high blood pressure?
- ☐ History of stroke?
- ☐ History of diabetes
- ☐ Other:

Physician's Comments

Print Name and DOB Label

HEART & VASCULAR
CENTER OF NORTH HOUSTON

MEDICAL HISTORY FORM

Medical History (Continued) Review of Systems

Review the list below and check "Y" for YES and "N" for NO
in line appropriate box for any problems you are currently having.

Constitutional

- Chronic fatigue or tiredness ☐ Yes ☐ No
- Nausea, chronic ☐ Yes ☐ No
- Night sweats ☐ Yes ☐ No
- Trouble with swallowing ☐ Yes ☐ No
- Vomiting ☐ Yes ☐ No

Ear, Nose, And Throat

- Change in voice ☐ Yes ☐ No
- Difficulty smelling things ☐ Yes ☐ No
- Difficulty with hearing ☐ Yes ☐ No
- Difficulty with vision ☐ Yes ☐ No
- Double vision ☐ Yes ☐ No
- Excessive sneezing ☐ Yes ☐ No
- Trouble breathing through nose ☐ Yes ☐ No
- Nose bleeds ☐ Yes ☐ No
- Ringing in ears ☐ Yes ☐ No

Respiratory

- Shortness of breath at night ☐ Yes ☐ No
- Shortness of breath walking ☐ Yes ☐ No
- Swelling of ankles or feet ☐ Yes ☐ No

Cardiovascular

- Chest pain or lightness ☐ Yes ☐ No
- Cough ☐ Yes ☐ No
- Cough up blood ☐ Yes ☐ No
- Heart attacks ☐ Yes ☐ No
- High blood pressure ☐ Yes ☐ No
- Palpitations ☐ Yes ☐ No
- Swelling of legs ☐ Yes ☐ No
- Wheezing during breathing ☐ Yes ☐ No

Gastrointestinal

- Black, loose bowel movements ☐ Yes ☐ No
- Constipation, chronic ☐ Yes ☐ No
- Diarrhea, chronic ☐ Yes ☐ No
- Blood in bowel movements ☐ Yes ☐ No
- Hemorrhoids ☐ Yes ☐ No
- Jaundice (yellow skin) ☐ Yes ☐ No
- Loss of appetite ☐ Yes ☐ No
- Stomach pain ☐ Yes ☐ No
- Stomach ulcers ☐ Yes ☐ No
- Vomit blood ☐ Yes ☐ No
- Weight loss ☐ Yes ☐ No
- Weight gain in past years ☐ Yes ☐ No

Genitourinary

- Blood in urine ☐ Yes ☐ No
- Difficulty starting urine stream ☐ Yes ☐ No
- Difficulty with ejaculation ☐ Yes ☐ No
- Difficulty with erection ☐ Yes ☐ No
- Discharge from penis ☐ Yes ☐ No
- Frequent urination ☐ Yes ☐ No
- Leakage of urine ☐ Yes ☐ No
- Passed a stone in the urine ☐ Yes ☐ No
- Puss or milky color of urine ☐ Yes ☐ No
- Reduction in force or volume of urine ☐ Yes ☐ No
- Urination at night ☐ Yes ☐ No

Musculoskeletal

- Change in glove, shoe, & hat size ☐ Yes ☐ No
- Back pain - High back area ☐ Yes ☐ No
- Back pain - Low back area ☐ Yes ☐ No
- Joint pain ☐ Yes ☐ No
- Joint swelling ☐ Yes ☐ No
- Muscle cramps in arms, legs, hands or feet ☐ Yes ☐ No
- Pain in hands or feet in cold weather ☐ Yes ☐ No
- Pain in legs while walking ☐ Yes ☐ No

Skin

- Dry skin ☐ Yes ☐ No
- Excessive sweating ☐ Yes ☐ No
- Hives ☐ Yes ☐ No
- Increase in hair growth ☐ Yes ☐ No
- Increase in oiliness of skin ☐ Yes ☐ No
- Itching of skin ☐ Yes ☐ No
- Prefer cold water ☐ Yes ☐ No
- Skin pailor (paleness) ☐ Yes ☐ No

Skin/Breast

- Breast discharge ☐ Yes ☐ No
- Excessive blistering after sun exposure ☐ Yes ☐ No
- Lumps in breast ☐ Yes ☐ No
- Painful breast ☐ Yes ☐ No

Heme/Lymph

- Easy bruising ☐ Yes ☐ No
- Excessive bleeding after cutting skin ☐ Yes ☐ No

Gynecology

- Bleeding between periods ☐ Yes ☐ No
- Duration of menstruation days ☐ Yes ☐ No
- Irregular periods ☐ Yes ☐ No
- Last menstrual period:____________ ☐ Yes ☐ No
- Last pelvic exam:____________ ☐ Yes ☐ No
- Length of interval between periods:____________ ☐ Yes ☐ No
- Onset of menstrual days:____________ ☐ Yes ☐ No
- Painful periods ☐ Yes ☐ No
- Vaginal discharge ☐ Yes ☐ No

Endocrinology

- Thyroid problems ☐ Yes ☐ No
- Sugar diabetes ☐ Yes ☐ No

Neurological

- Difficulty maintaining balance ☐ Yes ☐ No
- Headaches ☐ Yes ☐ No
- Numbness or tingling in hands, feet, arms, or legs ☐ Yes ☐ No
- Seizures or fits ☐ Yes ☐ No
- Strokes ☐ Yes ☐ No

Psychiatric

- Crying spells ☐ Yes ☐ No
- Depressions and anxiety ☐ Yes ☐ No
- Difficulty with memory ☐ Yes ☐ No
- Dizziness ☐ Yes ☐ No
- Insomnia ☐ Yes ☐ No
- Mood swings ☐ Yes ☐ No
- Nervousness ☐ Yes ☐ No
- Problem with memory ☐ Yes ☐ No
- Problem with thinking clearly ☐ Yes ☐ No

Other Medical History:____

Patient Name:____ DOB:____________

PATIENT CONSENT FORMS

Consent to Treat:

I hereby give my consent to **Heart & Vascular Center of North Houston** and authorize them to provide my medical care and treatment. I understand that Heart & Vascular Center of North Houston will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Heart & Vascular Center of North Houston to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

Notice of Privacy Practices Acknowledgement:

I acknowledge that Heart & Vascular Center of North Houston provided me the option to receive a written copy of the Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Authorization to Obtain/Release from Medical Providers & to Release Payment of Benefits:

I authorize the payment of benefits, as determined by Company, directly to Heart & Vascular Center of North Houston. I understand I still may be responsible for any amount not paid by my insurance company in the event that the charges made are not reasonable and customary.

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Initial

I hereby authorize Heart & Vascular Center of North Houston to release any medical records concerning my care, to any physician, hospital or other healthcare professional providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third party administrator or managed care company.

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Initial

Patient Name ____

Patient Signature ____ **Date** _________________

Parent or Legal Guardian Signature (for minor) ____

Relationship to the Patient ________________________________