TEXAS HEART AND VASCULAR SPECIALISTS, PA

Thank you for taking the time to review and choose our practice! We look forward to being part of your care team! The following pages are some information that will allow us to expedite your visit. Please note there are times where you may not be able to see your regular doctor due to an emergency. We will always try our best to be there for you but at times one of our partners may have to fill in. If you have any questions please feel free to contact us at any time.

PATIENT INFORMATION:

NAME (LAST, FIRST, MIDDLE): _____SEX:_____

DOB (MONTH/DAY/YEAR): _____SOCIAL SECURITY NUMBER:_____

MAILING ADDRESS (STREET, APT/UNIT):_____

(CITY, STATE, ZIP):_____

PHONE (HOME):__(____)_____ PHONE (CELL): ____(_____)_____

EMAIL ADDRESS:_____

EMPLOYER:_____WORK PHONE_(_____)_____

PRIMARY CARE DOCTOR: (NAME, LOCATION):_____

REFERRERING PROVIDER IF ANY (LOCATION):_____

EMERGENCY CONTACT INFORMATION:

NAME (LAST, FIRST)_____

PHONE:_(_____)_____RELATIONSHIP_____

INSURANCE INFORMATION:

NAME OF POLICY HOLDER (LAST, FIRST, MIDDLE): _____

DOB (MONTH/DAY/YEAR): _____SOCIAL SECURITY NUMBER:_____

MAILING ADDRESS (STREET, APT/UNIT):_____

(CITY, STATE, ZIP):_____

PHONE:(____)_____ RELATINOSHIP TO PATIENT:_____

INSURANCE COMPANY NAME: _____

POLICY NUMBER OR CERTIFICATE NUMBER:_____GROUP POLICY NUMBER_____

MAILING ADDRESS OF INSURANCE COMPANY:_____

PHONE OF INUSRANCE COMPANY:_(_____)_____ FAX NUMBER:_____

FAMILY HISTORY:

Please list any common medical problems that are found in your family and the family member with the diagnosis

_____

_____

SOCIAL HISTORY:

What do you do for a living?_____

Who lives with you?_____Do you feel safe at home?_____

How much alcohol do you drink each week:_____Do you or have you ever smoked? (yes or no)_____

Date of first exposure:_____ Current smoker or date of last exposure_____Average packs per day:_____

Tell us something interesting about you:_____

PAST MEDICAL HISTORY:

Please list any medical diagnosis you were given and the approximate date of diagnosis

_____

_____

_____

_____

PAST SURGICAL HISTORY:

Please list any surgeries you may have had the approximate date

_____

_____

DRUG ALLERGIES:

Please list any drug allergies or intolerances

_____

_____

CURRENT MEDICATIONS:

Please list current medications , the dose and length of therapy, include any supplements you may be taking as well

1._____2._____

3._____4._____

5._____ 6._____

7._____ _____8._____

9._____10._____

11._____12._____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____ _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____ _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _ _ _ _ _ _ _ _ _ _ _

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

WHAT IS THE REASON FOR YOUR VISIT? HOW CAN WE BE OF SERVICE?

All professional services rendered are charged to the patient. The patient is responsible for payment of doctors frees within 30 days regardless of insurance coverage or status of insurance claim(s). Extension of credit beyond 30 days must be discussed and approved by the business office in advance. Insurance payments received will be applied to your account balance or promptly refunded to you. Necessary forms will be completed and forward to the above insurance companies in order to expedite insurance carrier payments.

INSURANCE AUTHORIZATION AND ASSIGNMENT (please read and sign)

I hereby authorize Cardiology Associates, P.A. (partner of Texas Heart and Vascular Specialists PA) to furnish information to insurance carriers concerning my illness and treatments; and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for all charges regardless of insurance coverage.

_____

Signature of patient and date

_____

Signature of insurance policy holder if not patient and date