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Patient Registration Form

Plano / Hickory Creek / Irving / Arlington Telephone Number: (972) 939-8294
FAX: (214) 731-0240

TODAY'S DATE: ____/____/____ OFFICE LOCATION: HFPRE HICKORY CREEK IRVING ARLINGTON RECORD NUMBER: _____

PATIENT INFORMATION (Please use full legal name, no nicknames) (Mr.) (Mrs.) (Ms.) (Dr.)

Last Name _____ First Name _____ Middle Initial _____

Who referred you to our practice _____ ?

How would you like to be addressed by your physician _____ ?

Address _____ City _____ State _____ Zip Code _____

Home Phone # (____) _____ - _____ Mobile/Pager # (____) _____ - _____ Other (____) _____ - _____ Social Security # _____

Date of Birth ____/____/____ Age ____ Sex ____ Marital Status: (Married) (Divorced) (Single) (Widowed) Drivers Lic # _____

Employer Name _____ Address _____

Work Phone # (____) _____ - _____ E-Mail Address _____

Emergency Contact Name _____ Relationship _____

Emergency Phone (____) _____ - _____ Pharmacy Name: _____ Phone # (____) _____ - _____

GUARANTOR INFORMATION: (List person responsible for bill – use full legal name, no nicknames)

Relationship of Guarantor to Patient: (Self) (Spouse) (Parent) (Other) _____

If self and contact information is same as above, check here

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip Code _____

Date Of Birth ____/____/____ Age ____ Sex ____ Home Phone (____) _____ - _____ Work Phone # (____) _____ - _____

Employer Name _____ Address _____ City _____ ST _____ Zip _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards and Driver's License)

Primary Insurance

Plan Name _____ Insured's _____

Insured's Social Security # _____ - _____ - _____ Insured's Date of Birth ____/____/____

Policy / ID # _____ Group # _____ Effective Date _____

Claims Address _____ Phone # (____) _____ - _____

Secondary Insurance

Plan Name _____ Insured's Name _____

Insured's Social Security # _____ - _____ - _____ Insured's Date of Birth ____/____/____

Policy / ID # _____ Group # _____ Effective Date _____

Claims Address _____ Phone # (____) _____ - _____



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Patient Name: _____

First Name M.I. Last Name

Date of Birth: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I HEREBY AUTHORIZE DIRECT PAYMENT OF INSURANCE BENEFITS TO Texas Health MedSynergies or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Texas Health MedSynergies is unable to collect from my insurance carrier for whatever reason.

AUTHORIZATION TO RELEASE NON-PUBLIC INFORMATION:

I certify that I have read and been offered a copy of the Texas Health MedSynergies. "HIPAA Notice of Privacy Practices". I hereby authorize Texas Health MedSynergies and/or the physician individually to release any of my, or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

MEDICARE / MEDICAID INSURANCE:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Texas Health MedSynergies or the physician on my behalf.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

ACKNOWLEDGEMENT OF POTENTIAL FINANCIAL INTEREST IN ANCILLARY SERVICES:

I acknowledge that my treating physician may have a financial interest in the overall performance of ancillary services as part of his/her affiliation with a group practice. I understand that I should contact my treating physician if I have any questions regarding his/her potential financial interest in the ancillary services. I further understand that I am free to choose where I receive medical services and that I may discuss with my physician the availability of alternative treatment facilities if I so desire.

FINANCIAL DISCLOSURE – BAYLOR MEDICAL CENTER at Carrollton

This disclosure is being provided to you or your health care representative with the option you may be referred to Baylor Medical Center at Carrollton for further treatment or evaluation. I or my immediate family member has an ownership or investment interest in Baylor Medical Center at Carrollton. I am informing you of this financial interest to assist you in making an informed decision about your treatment options. Please let me know if you have any questions about my relationship to Baylor Medical Center at Carrollton or your treatment and evaluation options.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Texas Health MedSynergies physician or those under his/her supervision.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____



Medical Release of Information Form

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Previous Name: _____

I authorize HeartFirst to release
Copies of my results to:

I authorize HeartFirst Group to obtain copies
of my records from:

Name of Physician or Institution

Name of Physician or Institution

Address

Address

City, State, Zip

City, State, Zip

Reason for release:

This request and authorization applies to: (initial appropriate line)

_____ Health Care information relating to the following treatment condition or dates of treatment.

This information may contain x-ray reports, lab reports, EKG reports, other diagnostic reports, consults.

_____ All Health Care information including information relating to HIV/AIDS testing, sexually
transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle
all that apply.)

_____ All Health Care information excluding information relating to HIV/AIDS testing, sexually transmitted
diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that
apply.)

_____ I understand I have the right to revoke this authorization by providing a written request to do so to
the above named physician or organization. I understand that the revocation will not apply to
information that has already been released.

Signature of patient or authorized representative

Date

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal
representative, etc.)

Unless otherwise revoked, this Authorization will expire six months from the date signed. I
understand that authorizing the disclosure of this health information is voluntary. I understand that any
disclosure of information carries with it the potential for an unauthorized re-disclosure and the information
may not be protected by confidentiality rules.

Please be aware that our office charges a community standard fee for copying and sending medical
records, according to rules adopted by The Texas State Board of Medical Examiners. This fee is
\$25.00 for the first 20 (twenty) pages of records and \$0.50 for each additional page. The fee must
be paid prior to our office sending out your records. There is a \$35.00 fee for a CD copy of any
testing. Please give your phone number(s) below so that our Medical Records clerk can notify you
of the exact fee for copying and sending your records. Thank you.

Home Phone: _____

Work / Cell phone: _____



HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Heart First. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research

Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you do not want us to contact you via the phone numbers you have already provided, and/or leave a voice message via those phone numbers, please check the following box(es):

- Please do not contact me via the phone numbers provided to this practice

- Please do not leave a voice message via the phone numbers provided to this practice

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fundraising. Unless you request us not to, we may use your name and address to support our fundraising efforts. If you do not want to participate in fundraising efforts, please check off the following box.

Please do not use my information for fundraising purposes.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- ♦ The right to request restrictions on the use and disclosure of your protected health information;
- ♦ The right to receive confidential communications concerning your medical condition and treatment;
- ♦ The right to inspect and copy your protected health information;
- ♦ The right to amend or submit corrections to your protected health information;
- ♦ The right to receive an accounting of how and to whom your protected health information has been disclosed; &
- ♦ The right to receive a printed copy of this notice.

Practice Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this “Notice of Privacy Practices”.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:

HIPAA Privacy Officer
MedicalEdge Healthcare Group, Inc.
9229 LBJ Freeway
Dallas, TX 75243
(972) 739-3753

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.



Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

HeartFirst reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

Name of Patient (Print)

Date of Birth

Signature of Patient

Date of Signature

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls?

Yes No N/A

May we leave **messages** on a voice mail at work?

Yes No N/A

May we discuss your **appointments/treatment** with your spouse?

Yes No N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian?

Yes No N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children?

Yes No N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

Please place in the patient's medical record.

Date Seen: _____

Name: _____ DOB _____ MR# _____ Sex: _____

What is the name of the doctor who referred you to us? _____ Name of your family M.D. _____

WHY ARE YOU HERE to see a Cardiology heart doctor? _____

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

DOCTOR TO FILL OUT

Mark X on any HEART PROBLEMS or SYMPTOMS:

- Chest pains or pressure
- Abnormal rhythm arrhythmias
- Dizziness
- Angina
- Palpitations/Irregular heart beat
- Fainting
- Heart attack
- Heart murmur
- Leg cramps when you walk
- Heart failure
- Blue lips or fingernails
- Swollen legs
- Enlarged heart
- Shortness of breath

Please mark X if you have:

- Ever smoked? Yes No Year Quit _____ Packs per day _____
- Diabetes High blood pressure Overweight High triglycerides
- High cholesterol: Total _____ LDL _____ HDL _____ Trig _____

- For woman only:** Could you be pregnant? Yes No
- Have you passed menopause / change of life? Yes No
- At what age? _____ Do you take estrogen? _____

Has a close family member had:	Mother –	Father –	Sibling	Age Occurred	Cause of Death
A heart attack?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	<input type="checkbox"/>
Angina?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	<input type="checkbox"/>
Bypass surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	<input type="checkbox"/>
Carotid surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	<input type="checkbox"/>
Surgery of leg arteries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	<input type="checkbox"/>

Mark X if you have ever had any of the following PROCEDURES: Indicate approximate year of the procedure

- Stress test _____
- Coronary bypass surgery _____
- Valve surgery _____
- Electrocardiogram _____
- Electrophysiology Study or Procedure _____
- Cardiac catheterization / Heart catheterization _____
- Pacemaker or Defibrillator _____
- Coronary Angioplasty balloon arthrectomy / stent _____

Please list all illnesses you are being treated for now or have you been treated for. Please include date or year

1. _____ 3. _____
2. _____ 4. _____

Please list all injuries or surgeries you have had. Please include date or year

1. _____ 3. _____
2. _____ 4. _____

Social History:

- MARITAL STATUS: Single Married Separated Divorced Widowed
- Spouse name _____
- CHILDREN: Yes No # of Sons _____ # of Daughters _____
- OCCUPATION: _____
- MAJOR HOBBY: _____
- DIET: Regular No Added Salt Low Salt Low Fat / Chol Diabetic
- Other: _____
- ALCOHOL USE: Yes No Former Year Quit _____

- Rarely
- Frequently
- Socially
- Occasionally
- Daily

- EXERCISE: Sedentary Occasionally Regularly Active Lifestyle Physically Unable

Cardiac Hx

- CAD CHF/CM
- Arrhythmia PVD
- Valve Congen Other

HPI

- Onset: _____
- Frequency: _____
- Location: _____

RiskFx

Procedures

PMH

Social Hx Family Hx



Name: _____ DOB: _____ Date Seen: _____

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY

DOCTOR TO FILL OUT

Please tell us about your medicines names, dose or strength, how many times a day.
 Include over the counter medications and herbal medicines.
 Use doctor's column if necessary.

1.	Name		Dose		Frequency	
	ASPIRIN	YES NO	81mg	325mg	Enteric Coated	YES NO
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

Over the Counter Medications Herbs

1.			
2.			
3.			
4.			

Allergies:

Do you have any DRUG ALLERGIES? Yes No If yes, list them below

Are you allergic to IODINE, shrimp or shellfish?
 Yes No

Have you ever had a reaction to contrast dye? e.g. Myelogram, Kidney Series, CAT Scan
 Yes No

Have you had the following vaccinations?
 Influenza "Flu Shot" Annually Other
 Pneumococcal "Pneumonia" vaccine

Medications

Allergies

Vaccinations

PATIENT TO COMPLETE LEFT SIDE OF FORM ONLY						DOCTOR TO FILL OUT		
REVIEW OF BODY SYSTEMS: Please mark X YES or NO for each SYMPTOM.								
CARDIAC								
	YES	No		YES	No		YES	No
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diaphoresis	<input type="checkbox"/>	<input type="checkbox"/>	Orthopnea	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Passing out	<input type="checkbox"/>	<input type="checkbox"/>	PND	<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR								
Claudication	<input type="checkbox"/>	<input type="checkbox"/>	Edema	<input type="checkbox"/>	<input type="checkbox"/>			
CONSTITUTIONAL								
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>						
HEENT								
Visual Changes	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Ringling	<input type="checkbox"/>	<input type="checkbox"/>
PULMONARY								
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis Exposure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
GASTROINTESTINAL								
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Black or Tarry stools	<input type="checkbox"/>	<input type="checkbox"/>			
GENITOURINARY								
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urinations at night	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL								
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>						
PSYCHOLOGICAL								
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>
HEMATOLOGIC								
Acute anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thrombocytopenia	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
REPRODUCTIVE								
Oral contraceptives	<input type="checkbox"/>	<input type="checkbox"/>						
ENDOCRINE								
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>			
DERMATOLOGICAL								
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Skin sores	<input type="checkbox"/>	<input type="checkbox"/>			
MUSCULOSKELETAL								
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pains	<input type="checkbox"/>	<input type="checkbox"/>			

PHYSICAL EXAM

BP: L _____
 BP: R _____
 Pulse: _____
 Resp: _____
 Weight: _____
 Height: _____

PHYSICAL FINDINGS
CONST:

HEENT:
PULM:
THORAX:
CARDIAC:
ABD:
VASC:
EXT:
DERM:
MS:
NEUROPSYCH:
PROC SITE:

ASSESSMENT

- 1.
- 2.
- 3.
- 4.

PLAN

- 1.
- 2.
- 3.
- 4.

TESTING ORDERED