# Alabama Heart & Vascular Medicine

New Patient Information Form

DATE: ACCT NUMBER:

Patient Name: (First) (Middle) (Last)

Date of Birth:

Age:

Marital Status: Married/Single/Widowed/Divorced

Mailing Address: (Street) (City) (Zip Code)

Phone Numbers: Home:

Cell:

Work:

Email: Male/Female Social Security No:

Did another physician refer you here? Y/N Referring Physician:

Who is your family physician:

Language: English/Spanish/Other Race:

Ethnicity: Nonhispanic/Hispanic

(Circle)

Employed: Yes/No/Retired Employer:

Pharmacy Name: Phone No:

#### INSURANCE INFORMATION

Primary Insurance Name: Contract Number: Insured’s Name:

Effective Date: Group Number: Insured’s DOB:

Patient’s relation to insured party: Self/Spouse/Parent/Child/Other Male/Female

Secondary Insurance Name: Contract Number: Insured’s Name:

Effective Date: Group Number: Insured’s DOB:

Patient’s relation to insured party: Self/Spouse/Parent/Child/Other Male/Female

##### Please have your Driver’s License and all Insurance Cards available for us to scan. Thank you.

Who can we contact in case of an emergency?

Name:

Phone:

Relation:

I hereby authorize Alabama Heart & Vascular Medicine to release any medical information needed by my insurance carriers in order to process my claim. I hereby authorize payments direct to Alabama Heart & Vascular Medicine. I understand that it is my responsibility to provide correct insurance information to Alabama Heart & Vascular Medicine. **I understand that my insurance may not pay the bill and that some services may be considered “noncovered or not medically necessary” by my insurance contract. I understand that I will be responsible for the balance of my account.**

Date: Date: Patient’s Signature (Agreement to Pay) Guarantor’s Signature (Agreement to Pay)

# Alabama Heart & Vascular Medicine

G. Phil Hemstreet, M.D., Bradley Titus, M.D.  
Dana L. Hemstreet, CRNP Jeremy A. Kelley, CRNP  
Amy Moore, CRNP

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Alabama Heart & Vascular Medicine’s Notice of Privacy Practices.

Please Print Name

Patient or Responsible Party Signature Date Signed

## Consent to Release Information

I (the patient or responsible party) hereby authorize Alabama Heart & Vascular Medicine, it’s physicians, agents, employees, or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc. to the person(s) listed below.

Spouse Name:

Parent(s) Name(s):

Child/Children Name(s):

Other: Name(s):

**Alabama Heart and Vascular Medicine**

Authorization to Release or to Obtain Medical Information  
Fax (205) 345-4921

Patient Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_   
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
I, the undersigned, authorize and request **Alabama Heart and Vascular Medicine to \_\_\_\_ release or to  
 \_\_\_\_ obtain medical information from the following:**Physician/Organization/Individual(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ DCH Regional Medical Center or Northport Medical Center, 809 University Blvd., Tuscaloosa or 2700 Hospital Drive, Northport, AL, 205-759-7111 or 205-333-4500  
Or other Hospital(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_

Please identify the information to be released/obtained:

\_\_\_ Complete Record

\_\_\_ *Lab Results (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_ X-Ray/Imaging (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

The identified information will be used for the following purposes:   
\_\_\_\_ Sharing with my other healthcare providers  
\_\_\_\_ *For my personal records*

*\_\_\_\_ Moving   
\_\_\_\_ Other (specify)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please initial each item below to indicate your understanding:

\_\_\_\_\_ I understand the information in my health record may include information relating to STD’s, AIDS, or HIV. It may also include information relating to behavioral or mental health services, and treatment for drug and alcohol abuse.

\_\_\_\_\_ When my information is used or disclosed pursuant this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization at any time in writing and understand my revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

\_\_\_\_\_ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Parent, \_\_\_\_\_ Legal Guardian, \_\_\_\_ Other (please specifiy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

This authorization will expire on (insert date or event): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
**If I do not specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.**

Patient Name: Date of Birth: Date:

##### *Please check and add details out to the side*

**PAST MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Anemia |  | Liver disease |
|  | Asthma |  | Murmur |
|  | Aneurysm: abdominal |  | Irregular heart rhythm |
|  | Aneurysm: Thoracic |  | MVP (mitral valve prolapse) |
|  | Arthritis |  | PAH (Pulmonary Artery Hypertension) |
|  | Atrial Fibrillation |  | Phlebitis |
|  | Atrial Flutter |  | Pleurisy |
|  | Coronary Artery Disease |  | PUD (peptic ulcer disease) |
|  | Cancer |  | Pulmonary Embolism |
|  | Cellulitis |  | PVD (peripheral vascular disease) |
|  | Claudication |  | Renal Failure |
|  | Congestive Heart Failure |  | Renal Insufficiency |
|  | Connective Tissue Disease (Lupus, Sarcoidosis, etc.) |  | Rheumatic fever |
|  | COPD (chronic obstructive pulmonary disease) |  | Rheumatic heart disease |
|  | CVA/Stroke |  | Seizure Disorder |
|  | Deep Vein Thrombosis |  | SVT (supraventricular tachycardia) |
|  | Diabetes ( insulin or non-insulin dependent |  | Syncope |
|  | Dialysis |  | TB (tuberculosis) |
|  | Endocarditis |  | Thyroid disorder |
|  | Gastrointestinal Bleed |  | TIA (transient ischemic attack) |
|  | Gastroesophageal reflux disease (GERD) |  | Valvular Heart Disease |
|  | Heart block |  | Ventricular Tachycardia |
|  | Hypertension |  | Other: |
|  | Lipid disorder |  |  |

**SURGICAL HISTORY**

Please check and list dates/facility/surgeon

|  |  |  |  |
| --- | --- | --- | --- |
|  | Abdominal surgery |  | Gallbladder surgery |
|  | Amputation: above knee |  | Heart cath (dye test) |
|  | Amputation: below knee |  | ICD (Defibrillator) |
|  | Anesthesia problems |  | ICD: BI-V |
|  | Aneurysm Repair |  | Mitral Valve Repair |
|  | Aortic Valve Repair |  | Mitral Valve Replacement |
|  | Aortic Valve Replacement |  | Pacemaker |
|  | Appendectomy |  | PTCA/Angioplasty/stent) heart |
|  | Arteriogram: Carotid Legs Kidneys |  | PTCA (Angioplasty/stent) leg Kidney |
|  | Bypass: Aorta-femoral: left right |  | Stent: Aorta Carotid Iliac |
|  | Bypass: Fem-pop left right |  | Surgical Complications |
|  | CABG (open heart) |  | Thyroid Surgery |
|  | Congenital heart surgery |  | Other operations: |
|  | Endarterectomy Lt carotid Rt carotid |  |  |
|  | EPS (Electrophysiology Study) |  |  |
|  | MI (heart attack) |  |  |

Patient Name: Date:

##### Home Medications:

List all medications & dosage you are presently taking and how frequently you take them:

#### FAMILY HISTORY

***Please check box and circle the family member***

* Aortic Aneurysm [father, mother, sibling, grandparent]
* Asthma [father, mother, sibling, grandparent]
* Bleeding Disorder [father, mother, sibling, grandparent]

##### Medication/Dose/Frequency:

* Cancer

[father, mother, sibling, grandparent]

##### Please list all known allergies:

* Congestive Heart Failure [father, mother, sibling, grandparent]
* Connective Tissue Disease [father, mother, sibling, grandparent]
* Coronary Artery Disease [father, mother, sibling, grandparent]
* Coronary Heart Disease – male < 55 [father, mother, sibling, grandparent]
* Coronary Heart disease – female < 55 [father, mother, sibling, grandparent]
* CVA or stroke [father, mother, sibling, grandparent]
* Diabetes [father, mother, sibling, grandparent]
* Hyperlipidemia [father, mother, sibling, grandparent]
* Hypertension [father, mother, sibling, grandparent]
* Marfan’s Syndrome [father, mother, sibling, grandparent]
* Pulmonary Artery Hypertension [father, mother, sibling, grandparent]
* Peripheral vascular disease [father, mother, sibling, grandparent]
* Prolonged QT [father, mother, sibling, grandparent]
* Renal Disease [father, mother, sibling, grandparent]
* Sudden Cardiac Death [father, mother, sibling, grandparent]
* Thyroid Disease [father, mother, sibling, grandparent]

Mother living? Yes No Age at death Father living? Yes No

Age at death Number of living brother & sisters Number of deceased brothers & sisters

#### SOCIAL HISTORY

Marital Status: Single/Married/Divorced/Widowed How many children do you have? What is your occupation: Disabled Retired

##### Smoking History:

Current Smoker: year started Cigarettes: packs per day Cigars: number per day Smokeless: amount per day Counseled to quit or cut down: Yes No Former Smoker: year quit

##### Never smoked:

Passive smoke exposure: Yes No

Do you drink alcoholic beverages? Yes No

Types of Alcohol? How many drinks per day?

Drug Use? Yes No (If yes circle type below) Marijuana, cocaine, crack, heroin, illicit prescription

Other:

Do you drink caffeinated drinks? Yes No

How many per day? Do you drink diet drinks? Yes No

Are you on a special diet? Yes No Calorie Limited Low Salt

Low Fat Diabetic

High Fiber Low Cholesterol

Other

Do you exercise on a regular basis? Yes No How many times per week? Type of exercise?

Do you have a barrier to communication? Yes No High Risk Behavior? Yes No

Comments:

Patient Name: Date of Birth: Date:

***Review of Systems (please check if you have any of the following)***

### General

* Daytime sleepiness
* Weakness
* Weight Gain
* Weight Loss

### Cardiovascular

* Chest pain
* Fainting
* Heart racing (palpitations)
* Swelling in feet/legs (peripheral)

### Respiratory

* Cough
* Excessive snoring
* Shortness of breath
* Wheezing

### Neurologic

* Dizziness (lightheadedness)
* Morning headaches

### Gastro-Intestinal

* Constipation
* Diarrhea
* Bloody stools
* Indigestion
* Dark tarry stools
* Nausea/Vomiting

### Genital-Urinary

* Difficult urination (dysuria
* Blood in urine (hematuria)

### Musculo-Skeletal

* Leg pain
* Muscle cramps

### Dermatologic

* Non-healing ulcer
* Scar to chest
* Scar to leg

### Ears, Nose, Throat

* Hoarseness
* Nosebleed

### Psychiatric

* Anxiety
* Depression

### Allergies

* Allergic to Iodine
* Allergic to medications
* Allergic to shellfish
* Allergic to dye

Form Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: Date of Birth: Date:

**Vascular Screening**

## History

### Varicose veins are large, bulging veins, as opposed to spider veins, which are thin, branching veins just beneath the skin’s surface. Have you ever had varicose veins? \_\_\_\_\_\_

## Signs and Symptoms Do you experience any of the following signs and symptoms in your legs or ankles? Leg pain, aching or cramping\_\_\_\_\_ Burning or itching of the skin\_\_\_\_\_

Leg or ankle swelling, especially at the end of the day\_\_\_\_\_  
A feeling of heaviness in legs \_\_\_\_\_\_

Pain from prolonged sitting or standing \_\_\_\_\_  
Skin discoloration or texture changes, such as above the inner ankle\_\_\_\_\_  
Open wounds or sores, such as above the inner ankle\_\_\_\_\_  
Restless legs\_\_\_\_\_

## Risk Factors Has anyone in your blood-related family ever had varicose veins or been diagnosed with chronic venous insufficiency or venous reflux? Yes\_\_\_\_\_ No\_\_\_\_\_

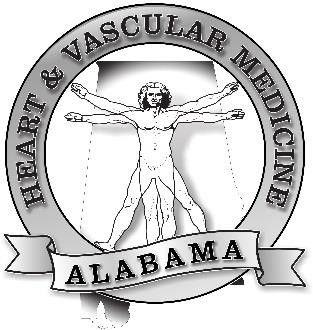
## Have you had a blood clot in a vein that cause inflammation, pain, or irritation? Yes\_\_\_\_\_ No\_\_\_\_\_

## Do you have ropey veins or veins that are raised above the skin in your legs? Yes\_\_\_\_\_ No\_\_\_\_\_

## Have you had any treatments or procedures for vein problems? Yes\_\_\_\_\_ No\_\_\_\_\_ Do you stand for long periods of time, such as at work? Yes\_\_\_\_\_ No\_\_\_\_\_

## Do you suffer from tingling, numbness, burning or cramping in legs or feet? Yes\_\_\_\_\_ No\_\_\_\_\_ Do you frequently engage in heavy lifting? Yes\_\_\_\_\_ No\_\_\_\_\_ Do you have skin discoloration on your lower legs? Yes\_\_\_\_\_ No\_\_\_\_\_

## Do you have hard to heal ulcers or sores on your lower legs? Yes\_\_\_\_\_ No\_\_\_\_\_ If female, have you ever been pregnant? Yes\_\_\_\_\_ No\_\_\_\_\_

**ALABAMA HEART & VASCULAR MEDICINE**

PHONE MESSAGE CONSENT FORM

Your physician(s) and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL NOT:

* + LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT OR LEGAL GUARDIAN.
  + LEAVE INFORMATION ON AN ANSWERING MACHINE
  + LEAVE INFORMATION ON A VOICEMAIL

Please read below and consider carefully whom you want to have access to your medical information.

I give Alabama Heart & Vascular Medicine my permission to leave phones messages regarding my medical care and test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.

My cell phones: ( ) -

My home answering machine/voicemail: ( ) - My office/work voicemail: ( ) -

initials: initials: initials:

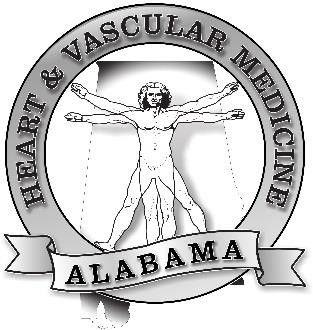
My medical care may be discussed with the following:

My spouse: at ( ) - Other: at ( ) -

initials: initials:

 **I DO NOT WANT MY INFORMATION LEFT ON VOICEMAIL**

Patient/Guardian Signature Date

**Alabama Heart & Vascular Medicine**

**No Show Policy**

Due to the negative impact that NO SHOWS have on our schedule we have developed a no-show policy. To better serve you and our other patients we now require a minimum notice for cancellations. By signing this document, you are acknowledging that you understand and agree to our advance notice policy and the applicable NO SHOW fee associated.

24-Hour Notice Required for:  
**Office visit no-show fee of $50  
Nuclear stress test no-show fee of $250**  
48-Hour Notice Required for:  
**Procedure no-show fee of $500**

If you fail to notify our office prior to your visit your account will be charged the applicable no-show fee and you will be responsible for paying the charge prior to rescheduling.

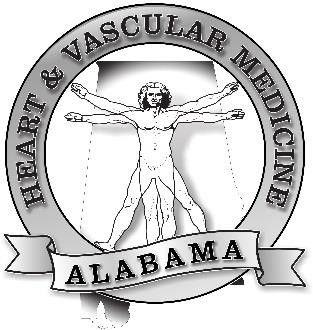
If you miss three appointments within one year, you will be subject to dismissal from the practice.

\*\*The only exception to this policy will be made in case of a true emergency. \*\*

Thank you!

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: Date: \_\_\_\_

**Alabama Heart & Vascular Medicine**

**Photo Policy**

I consent that a statement/interview, and/or photograph, and/or illustration, and/or video, and/or audio recording may be taken of me by Bama Heart Doc, P.C., d/b/a Alabama Heart and Vascular Medicine (“Alabama Heart & Vascular Medicine”) regarding my personal and medical history, condition(s), and treatment(s) for the purposes of documentation, education, publication, promotion, marketing, or advertising activities, programs, and services.

I consent and grant permission to Alabama Heart and Vascular Medicine to the use of any such statement/interview, and/or photograph, and/or illustration, and/or video, and/or audio recording, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, which may include Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPPA), by Alabama Heart & Vascular Medicine for any lawful use Alabama Heart and Vascular Medicine deems appropriate, including for treatment, advertising his/her/its services to the general public (including via social media and electronic media), illustration, and publication to the public at large for educational, promotional, advertising, or marketing purposes. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by Alabama Heart and Vascular Medicine. I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that Alabama Heart and Vascular Medicine will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the extent possible.  I understand that Alabama Heart and Vascular Medicine cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Alabama Heart and Vascular Medicine may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my age, and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that Alabama Heart and Vascular Medicine may not and has not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness. I have read the foregoing in its entirety and understand its terms.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name Signature of Patient

Date