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: _____

Employed: Yes/No/Retired Employer: _____

Pharmacy Name:_____ Phone No: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____
Contract Number: _____ Group Number: _____
Insured's Name: _____ Insured's DOB: _____

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

Secondary Insurance Name: _____ Effective Date: _____
Contract Number: _____ Group Number: _____
Insured's Name: _____ 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

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): _____

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

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

SURGICAL HISTORY

Please check and list dates/facility/surgeon

- ☐ Abdominal surgery _____
- ☐ Amputation: above knee
- ☐ Amputation: below knee
- ☐ Anesthesia problems
- ☐ Aneurysm Repair
- ☐ Aortic Valve Repair
- ☐ Aortic Valve Replacement
- ☐ Appendectomy
- ☐ Arteriogram:____Carotid_____Legs_____Kidneys
- ☐ Bypass: Aorta-femoral:____left_____right
- ☐ Bypass: Fem-pop____left_____right
- ☐ CABG (open heart)
- ☐ Congenital heart surgery
- ☐ Endarterectomy_____Lt carotid_____Rt carotid
- ☐ EPS (Electrophysiology Study)
- ☐ MI (heart attack)
- ☐ Gallbladder surgery
- ☐ Heart cath (dye test)
- ☐ ICD (Defibrillator)
- ☐ ICD: BI-V
- ☐ Mitral Valve Repair
- ☐ Mitral Valve Replacement
- ☐ Pacemaker
- ☐ PTCA/Angioplasty/stent) heart
- ☐ PTCA (Angioplasty/stent) leg_____Kidney
- ☐ Stent:____Aorta_____Carotid_____Iliac
- ☐ Surgical Complications
- ☐ Thyroid Surgery
- ☐ Other operations:

_____

_____

_____

Patient Name:_____ Date: _____

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

Medication/Dose/Frequency:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all known allergies:

_____
_____

_____

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]
- ☐ Cancer _____ [father, mother, sibling, grandparent]

- ☐ 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 beneaththe 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 ofthe day_____

A feeling of heaviness in legs____

Pain from prolonged sitting or standing _____

Skin discoloration or texture changes, such asabove the inner ankle_____

Open wounds or sores, such as above the innerankle_____

Restless legs_____

Risk Factors

Has anyone in your blood-related family ever had varicose veins or been diagnosed withchronic 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: (_____)_____-_____ initials:_____

My home answering machine/voicemail: (_____)_____-_____ initials:_____

My office/work voicemail: (_____)_____-_____ initials: _____

My medical care may be discussed with the following:

My spouse:_____at (_____)_____-_____ initials:_____

Other:_____at (_____)_____-_____ 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