Patient Information

Please Print

Last Name	First Name	Middle Initial	Today's Date

Street Address	City	State	Zip Code

Sex M F	Employed? Y N	Email Address	SSN	Date of Birth	Home/Primary Phone #	Alternate Phone #

Employer's Name	Employer's Phone #	Extension Number

Employer's Street Address	City	State	Zip Code

Marital Status: Single Married Widowed Divorced Other	# of Insurance Plans	Reason for Visit

May we call you at home and leave a message? Y N (PLEASE SEE BOTTOM RIGHT TO AUTHORIZE US TO SPEAK WITH OTHERS ABOUT YOUR CARE)

How Did You Hear About Us? Family Friend Employer Phone Book Doctor (Name)________ Other	Do You Have a Living Will? Yes No

Insurance Information / Secondary Carrier

Insurance Information		Secondary Carrier	
Insurance Carrier		Insurance Carrier	
Insured's Last Name	First Name	Insured's Last Name	First Name
Address	Insured's SS Number	Address	Insured's SS Number
City, State, Zip, Code	Insured's Date of Birth	City, State, Zip, Code	Insured's Date of Birth
Insured's Employer Name & Address		Insured's Employer Name & Address	
Relationship to Guarantor: Self Spouse Parent Child Other	Insured's Sex M F	Relationship to Guarantor: Self Spouse Parent Child Other	Insured's Sex M F

In Case of Emergency, Who Should We Call?

Name	Relationship	Home or Primary Phone #	Alternate Phone #

Street Address	City, State, Zip Code

Consent for Treatment and Lifetime Authorization for Assignment of Benefits and Information Release

I hereby give consent to FLORIDA HEART GROUP to provide whatever treatment they deem necessary to the patient above.

Insured party must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that the information I furnish is true and correct.

I know it is a crime to fill out this form with facts that I know are false or to leave out facts I know are important.

I assign payment directly to the physicians of FLORIDA HEART GROUP which may be due me from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. I will notify FLORIDA HEART GROUP of any change in the above information.

Should the insurance information given be incorrect at time of service, I will be liable for payment of services rendered.

Signature of Responsible Person If Other Than Patient ______________________

Signature / Patient Authorization ______________________

Date ______________________

Consent to use of PHI:

You have the right to review / receive a copy of our Notice of Privacy Practices before you sign this consent. By signing this form, you consent to our use and disclosure of Personal Health Information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Signature ______________________

Who may we contact (family / friends) to discuss your medical care?

Please PRINT complete name(s) below:

Name	Phone	Relationship

1613 North Mills Avenue • Orlando, Florida 32803 • 407 894-4474 • 1-800-28-HEART (1-800-284-3278) • FAX 407 894-7032

Altamonte Springs • Orlando • Oviedo

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F03300 (11/09)

Health History Sheet

Please complete and bring to your office visit

Appointment Date:______________________________ (For office use only) Acct#:____________

Name:____

Age:_______ Date of Birth:________________ Marital Status:______________________

Employer:______________________________ Occupation:______________________________

Full time__________ Part time_________ Preferred Language:______________________

Referred by:______________________________ Family Dr.:______________________________

Referral Dr. Address:______________________ Family Dr. Address:______________________

______________________________________ ______________________________________

Referral Dr. Phone:________________________ Family Dr. Phone:________________________

Allergies

Have you ever or are you? **Please check all that apply**

Allergic to any medications: List:		allergic to foods	
Allergic to seafood		Allergic to iodine	
Seasonal allergies		Had a reaction to iodine or IV contrast	

Medications

Preferred Pharmacy:_____________________________ Location:______________________

Name of Medication	Dosage	Administering Instructions

Infection History

Have you ever had? **Please check all that apply to you**

HIV		Rheumatic Fever	
MAC		TB (Tuberculosis)	
Hepatitis			

History of Present Illness

Have you recently experienced:	Yes	No
Chest pain/pressure, tightness, heaviness		
Dizziness, passing out, fainting		
Shortness of breath		
Irregular heart beat		
Swelling – where		
Pain in legs with exercise		

Past Medical History

Have you ever been diagnosed with any of the following? **Please check all that apply to you**

Abdominal Aneurysm		Congestive heart failure/fluid in lungs	
Asthma		Depression	
Anemia		Diabetes	
Anxiety		Emphysema/COPD/Lung problems	
Arthritis		GERD / Acid indigestion	
Cancer-breast		Gout	
Cancer-bladder		Hiatal Hernia	
Cancer-colon		Kidney disease	
Cancer-liver		Leg or hip cramps	
Cancer-lung		Liver disease	
Cancer-pancreas		Menstrual problems	
Cancer-prostate OR prostate enlargement		Neck: large artery blockage	
Cancer-stomach		Parkinson's disease	
Cancer-Uterus		Seizures	
Cancer-Skin		Stomach ulcer or bleeding ulcer	
Colitis		Stroke with or without paralysis	
Congenital heart disease		Thyroid problems	

Past Cardiac History

Have you ever had? **Please check all that apply to you**

Chest pain (Angina)		High cholesterol	
Congestive Heart Failure		Hypertension	
Heart murmur/Valve disease		Atrial fibrillation (Irregular heart beat)	
Heart attack How many: Date(s):		Coronary artery disease (blockage of heart arteries	

Cardiac Risk Factors

Have you ever or do you currently? **Please check all that apply to you**

Smoke cigarettes currently		Diabetes	
Used to smoke but quit		Previous heart disease	
Family history of heart disease (under 50)		History of obesity	
High Cholesterol		Reached menopause	
High blood pressure		Take hormones	

Cardiac Procedures

Have you ever had? **Please check all that apply to you**

EP Study (Electrophysiology)		Ablation	
Event Monitor		Holter Monitor	
Stress Test		Echocardiogram	
Cardioversion		Kidney / renal procedure	
Heart Catheterization How many: Date(s)		PTCA (Balloon Angioplasty) How many: Date(s)	
Stent placement in artery How many: Date(s):		Heart bypass surgery How many: Date(s):	
Pacemaker / ICD placement		Other	

Surgical History

Have you ever had any of the following operations? **Please check all that apply to you**

Heart valve replacement		Hip replacement	
Appendectomy		Lung surgery	
Breast surgery		Knee replacement	
Carotid Artery surgery (neck)		Thyroid surgery	
Cataract removal		Prostate surgery (TURP)	
Gallbladder removal		Varicose vein stripped	
Hemorrhoid surgery		Hysterectomy	
IVC Filter		Fistulas	
Ports		Other	

Social History / Other Cardiac Risk Factors

Do you? **Please check all that apply to you**

Drink alcohol regularly		No Caffeine	
Drink alcohol occasionally/socially		Occasional Caffeine	
Smoke currently		Daily Caffeine	
Used to smoke but quit		No regular exercise	
No diet modifications		Some exercise	
Eat a low salt / low cholesterol diet		Exercise regularly	
Low fat diet		Use of illegal drugs	
Diabetic diet		Single Married Divorced Widowed (circle one)	
Vegetarian diet			

Family History

Have your father, mother, brothers, or sisters ever had? **Please check all that apply**

Heart Attack		Diabetes	
Congestive heart failure		Heart Valve problems	
Stroke		High blood pressure	
Bleeding disorders		Thyroid disease	
Kidney problems		Family heart problems (prior to age 50)	

Review of Systems

Please check all that apply to you:

General Constitution		Gastroenterology	
Recent weight gain/loss		Change in bowel habits, constipation	
Decreased exercise tolerance		Current blood or mucus in stools	
Fatigue		Feeling of fullness, bloating	
Fever/chills		**GI Male/Female**	
Integumentary		Urinary problems	
Skin pain/sensitivity		**Musculoskeletal**	
Rash/hives		Arthritis	
Eyes		Muscle pain/weakness	
Glaucoma		Blood clots in legs	
Wear glasses/contacts		Varicose Veins	
Partial vision loss		**Neurological**	
Cataracts currently		Difficulty speaking	
Ear Nose Throat		Confusion	
Hearing loss		Dizziness	
Dizziness/positional		**Psychiatric**	
Respiratory		Depression, anxiety	
Shortness of breath during walking or exercise		**Endocrine**	
Sleep with more than 1 pillow to help you breath		Thyroid disorders	
Snoring or coughing during sleep		Diabetic	
Unrested when you wake, nap frequently, or fall asleep during the day		**Hematological/Immunologic**	
Cardiovascular		Bleeding disorders	
Feet/ankle swelling		Nose bleeds	
Blackout or fainting spells		Anemia	
Palpitations			

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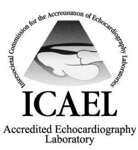

PRESCRIPTION MEDICATION REFILL POLICY

In our continuing effort to provide quality care and timely service we established a policy effective February 2006 regarding prescription medication refills.

<u>ALL</u> refill requests for medications ordered by your FHG physician must be obtained in writing at the time of your visit. Please make sure the nurse provides you with the number of refills needed until your next visit with your physician. If you normally use a mail order pharmacy make sure your prescription is written for a 3 month supply with 3 refills.

We understand that our policy may not be convenient; however we feel it allows us to provide a higher level of care by ensuring that you are receiving the right medications and that your physician is seeing you on a regular basis.

If you have a question or concern regarding your medication you may call our triage department at 407-894-4474 press 3 press 1. You will be asked to leave your name and number and your call will be returned no later than the next business day. The nurse will not be able to refill any medications; you must make an appointment with your physician or the nurse practitioner in order to obtain your refills.

THANK YOU!

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