HeartCare

6310 Health Park Way Suite 120
Lakewood Ranch, FL 34202
(941)-907-8951

New Patient Packet

Today's Date:_____
First Name: _____MI:____ Last Name: _____
Gender: Male/Female
Date of Birth: _____ Social Security Number:_____

Primary Care Provider:_____ Referring Provider: _____

(If you live out of state, please provide additional address)
Street Address: _____
City: _____ State:_____ Zip Code:_____

Street Address: _____
City: _____ State:_____ Zip Code:_____

Preferred Contact Information
Phone #: _____ Home/Cell/Work
Phone #: _____ Home/Cell/Work
Email: _____

Permission to receive information on (circle) appointments, testing, labs results, billing information, medical information via: (circle) phone, voicemail, mail.

Emergency Contact:

Name	Relationship	Phone Number

Names of individuals we may share your medical information with:

Name	Relationship	Phone Number

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Preferred Pharmacy
Pharmacy Name: _____
Pharmacy Phone #: _____

Insurance Information
Primary:
Company: _____ Subscriber: _____
Policy:_____ Group: _____

Secondary:
Company: _____ Subscriber: _____
Policy:_____ Group: _____

Social History
Marital Status: Single/Married/Divorced/Widowed

Number of Biological Children: ___

Tobacco Use: Current/Former/Never

Current: Cigarettes/Cigars/Pipe/Chewing Tobacco
Amount per day: _____ Number of years: _____

Interested in quitting?: YES/NO
Former: Cigarettes/Cigars/Pipe/Chewing Tobacco
Year Quit: _____ Amount per day: _____
Number of years: _____

Alcohol Use: Yes/No
Beer/Liquor/Wine
Number of drinks/week: _____

Employment: Employed/Retired/Disabled
Type of Employment: _____

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Past Medical History

(Circle if you have ever had any of the following health issues)

Coronary Artery Disease	Rheumatic Fever	Kidney Disease
Coronary Artery Bypass Surgery	Carotid Artery Disease	Acid Reflux
Heart Attack	Abnormal EKG	
Angioplasty/Coronary Stents	Aneurysm	
Pacemaker/Defibrillator	Diabetes	
Valvular Heart Disease	High Cholesterol	
Arrhythmia	Cardiomyopathy	
Obesity	Congestive Heart Failure	
Sleep Apnea	Liver Disease	
Renal Artery Disease	Arthritis	
Stroke	Gout	
TIA	Thyroid Disease	
Peripheral Vascular Disease	Depression	
High Blood Pressure	Anxiety	
Bowel Disease	Peptic Ulcer Disease	
Anemia	Gall Bladder Disease	

Other: _____

Past Surgical History (Please Include Dates)

_____ _____

_____ _____

_____ _____

Family Medical History

(Circle any cardiac conditions that run in your immediate family)

Heart Disease	Diabetes
Stroke	Aneurysm
High Blood Pressure	Arrhythmia

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Father Living/Deceased	Cause of Death:_____	Age of Death:_____
Mother Living/Deceased	Cause of Death:_____	Age of Death:_____
Brothers Living/Deceased	Cause of Death:_____	Age of Death:_____
Sisters Living/Deceased	Cause of Death:_____	Age of Death:_____

Allergies (please list all medication and food allergies)

Medication Reaction

_____ Allergy to Shellfish/Iodine? ☐

_____

_____

_____

_____

Medication List (please include Aspirin and Vitamins/Supplements)

Name Dosage Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Vein Disorder Questionnaire

1. Do you have swollen ankles or legs? YES/NO
2. Are leg symptoms worse in the evening? YES/NO
3. Do you have Restless Leg Syndrome (RLS)? YES/NO
4. Do you have ropey or bulging varicose veins? YES/NO
5. Any bleeding from spider or varicose veins? YES/NO
6. Sores or ulcers on your legs? YES/NO
7. Thickening and discoloration of the legs or ankles? YES/NO
8. Nighttime cramping? YES/NO
9. Vein related symptoms in your family? YES/NO

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Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by HeartCare for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or o conduct health care operations of HeartCare. I understand my diagnosis or treatment of me by HeartCare may be upon my consent as evidenced by my signature on this document.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of HeartCare.

HeartCare is not required to agree to the restrictions that I may request. However, if HeartCare agrees to a restriction that I request, the restriction is binding of HeartCare.

I have the right to revoke this consent, in writing, at any time, except to the extent that HeartCare has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review HeartCare's Notice of Privacy Practices prior to signing this document. HeartCare's Notice of Privacy Practices has been provided to me. The Notice of Privacy describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of the health care operations of HeartCare. The Notice of Privacy Practices for HeartCare is also provided in our waiting room. The Notice of Privacy Practices also describes my rights and the HeartCare's duties with respect to my protected health information. HeartCare reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of the Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Description of PR's Authority

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Assignment of Insurance Benefits

Medical and Supplemental Insurance

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicare Services (CMS) and its agents and/or any supplemental insurance companies any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to HeartCare on my behalf for any services furnished for me or by HeartCare, including physician and midlevel services. I authorize HeartCare to act as my agent and help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, HeartCare may prescribe testing procedures to be performed here. I understand, and have been advised that, according to Florida Law, I am under no obligation to use this facility. **I understand that I am responsible for full payment of any charges, including non covered services, deductibles, and/or copayments due.**

_____ _____

Patient Signature Date

_____

Printed Name

Commercial Insurance

I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. I request that payment of authorized benefits be made on my behalf to HeartCare for any services provided by HeartCare physicians or midlevel providers. **I understand that I am responsible for full payment of any charges, inducing non-covered services, deductible and or copayments due. I further understand that I am responsible to notify this office of any pre-authorization or pre-certification required by my insurance company. It is my responsibility to ensure that an authorization is on file with HeartCare prior to having my procedure performed. When applicable, I understand that I am responsible for full payment of all charges in the absence of authorization.**

_____ _____

Patient Signature Date

_____

Printed Name

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Authorization for Release of Health Information

Patient Name: _____Date of Birth:_____
Social Security Number:_____
Address:_____
Phone Number: _____

I authorize HeartCare to:
( ) Send my records to: ( ) Obtain my records:

_____
Name of Physician/Facility

_____
Address City State Zip Code

_____
Phone Number Fax Number

For the purpose of ( ) Continued Medical Care ( ) Personal Use ( ) New Patient

Information to be released:

_____

_____

I understand that my records may contain information about alcohol and or drug treatment, mental health or psychiatric treatment and/or HIV/AIDS information. I do hereby expressly and voluntarily consent to the disclosure of my health information as specified, for the purpose or need as indicated above.

I understand HeartCare may utilize a medical record correspondence service and that there may be a fee assess for this service (Please allow 7-10 business days for records to be copied)

I understand this consent will expire 12 months after the date below, or when the information requested with this consent has been released. A photocopy of this authorization shall have the same effect as the original.

_____ _____ _____

Signature of Patient/Legal Representative Relationship to patient Date

HeartCare

HIPAA Privacy Authorization/Medical Information Release Form

We cannot discuss your health information with anyone other than yourself (including spouse) unless you provide us with authorization to do so. Please list below names of the individual(s) you authorize our office to discuss care with.

*This authorization includes appointment information, complete medical information including treatment plan and/or diagnosis, billing and claim information, and any other pertinent medical information contributed to my health care plan or treatment and care.

I authorize HeartCare to disclose/discuss my protected health information described above with:

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

_____ _____

Signature of Patient DATE OF BIRTH Date

_____

Printed Name of Patient

6310 Health Park Way Suite 120, Bradenton, FL 34202

(941) 907-8951 Fax: (941) 907-3015