

**FEDERALLY MANDATED ELECTRONIC HEALTH RECORD
PATIENT DEMOGRAPHIC INFORMATION**

Patient Name _____

Date of Birth _____

The Heart Care Center wants to make communicating with our patients as convenient for you as possible. We will be using an automated appointment confirmation system which will contact you by phone. This system will be tailored to your preferred method of communication – either voice or text. For this purpose, please choose one of the following options:

CHOOSE ONLY ONE OPTION BELOW:

Option # 1 – I want to be contacted by a voice phone message:

Preferred phone # _____ Home Cell Work

Option # 2 – I want to receive a text (SMS) message:

Cell Phone # _____

Preferred Language: English Spanish

Preferred Time: Morning Afternoon Evening

E-Mail Address: _____

Please answer these additional questions to complete your patient record with our office to comply with recent Federal mandates:

Race:

<input type="checkbox"/>	Black	<input type="checkbox"/>	Other Pacific Islander
<input type="checkbox"/>	Hispanic or other Latin	<input type="checkbox"/>	Native Alaskan
<input type="checkbox"/>	White	<input type="checkbox"/>	American Indian
<input type="checkbox"/>	Native Hawaiian	<input type="checkbox"/>	Other Race
		<input type="checkbox"/>	Unreported

Ethnicity:

<input type="checkbox"/>	Caucasian
<input type="checkbox"/>	Hispanic
<input type="checkbox"/>	African American
<input type="checkbox"/>	Asian

Language:

<input type="checkbox"/>	English
<input type="checkbox"/>	Spanish
<input type="checkbox"/>	Indian (includes Hindi & Tamil)
<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Japanese
<input type="checkbox"/>	Vietnamese

REQUEST FOR CONFIDENTIAL COMMUNICATION

This form is used to request alternate communication of confidential patient information. This form must be filled out completely and returned to our office. (PLEASE PRINT)

Patient Name: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Social Security Number: _____ Birth Date: _____

Instructions per patient: _____

Persons to whom information may be disclosed:

_____	Relationship: _____
_____	Relationship: _____
_____	Relationship: _____
_____	Relationship: _____
_____	Relationship: _____

Patient Printed Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Personal Representative Name: _____ Date: _____

Representative's Signature: _____ Date: _____

Acknowledgement of Notice of Privacy Practices

The Heart Care Center of Northwest Houston's Privacy Practice is available for review upon request.

I acknowledge that I have the right to review The Heart Care Center of Northwest Houston's Patient Privacy Practices. I am aware that The Heart Care Center of Northwest Houston will use and disclose my health information to any physician, pharmacy, hospital, insurance company and/or other healthcare provider that is necessary for treatment, payment and healthcare operations.

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. This form is available at the front desk, upon your request. This authorization is effective through lifetime unless revoked or terminated earlier by the patient or the patient's personal representative in writing.

Name of Patient (Print or Type)

Signature of Patient

Date

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

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practices, but could not be obtained due to the following:

- Patient / Patient Representative refused to sign*
- Communications barriers prohibited obtaining the acknowledgement*
- An emergency situation prevented us from obtaining acknowledgement*
- Other:*

HEART CARE CENTER OF NORTHWEST HOUSTON, PA

Authorization for the Heart Care Center to Receive Protected Health Information from a Physician or Institution

Information regarding patient for whom authorization is made: Full Name: _____ Other Name Used _____ Date of Birth _____ Address _____ City _____ State _____ Zip _____ Phone _____ Email (Optional) _____
Please forward the requested health care information to: Heart Care Center of Northwest Houston, PA 13325 Hargrave Road # 150 Houston, TX 77070 Phone: 281-955-7863 Fax: 281-955-8617
The person or entity who can release this information: Name: _____ Address: _____ City _____ State _____ Zip _____ Phone: _____ Fax _____
Specific Information to be disclosed: ____ Medical Record from (insert date) _____ to (insert date) _____ ____ Entire Medical Record, including patient histories, office notes (except psychotherapy notes) test results, radiology studies, referrals, consults, billing records, insurance records and records received from other health professionals. ____ Other _____
Include: (Indicate by Initialing: ____ Drug, Alcohol or Substance Abuse Records ____ Mental Health Records ____ HIV/AIDS Related Information (including HIV AIDS Test Results ____ Genetic Information
Reason for release of Information: Choose all that apply) ____ Treatment/Continuing Medical Care ____ School ____ Personal Use ____ Employment ____ Billing or Claims ____ Disability Determination ____ Insurance ____ Other ____ Legal Purposes

The individual signing this form agrees and acknowledges as follows:

Voluntary Authorization: This authorization is voluntary. Treatment, payment, will not be conditional upon my signing of this authorization form.

Effective Time Period: This authorization shall be in effect until Month: _____ Day: _____ Year: _____. (Or 2 years after the death of the patient for whom this authorization is made which ever date is earlier)

Authorization to Receive Protected Health Information

Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Special Information: This authorization may include disclosure of information relating to **drug, alcohol and substance abuse, mental health information** (except psychotherapy notes), **confidential HIV/AIDS-related information**, and **genetic information** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signatures:

Patient/Legal Representative _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional) _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Minor's Signature (if applicable) _____ Date: _____

NEW PATIENT QUESTIONNAIRE

NAME: _____ **DATE:** _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING DR:** _____

(If different from PCP)

HOSPITAL FOLLOW UP FROM: ___ North Cypress Hospital ___ Methodist Willow brook ___ Houston Northwest
 ___ Cy-Fair ___ St. Luke Vintage

CHIEF COMPLAINT (Reason for visit): _____

PAST MEDICAL HISTORY (Illnesses or diseases) : Please circle all that apply

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> CAD
(heart disease/blockages) | <input type="checkbox"/> Valvular Heart Disease
(heart murmur) | <input type="checkbox"/> Arrhythmias
(irregular heart beat) | <input type="checkbox"/> CMOP/CHF
(weak/enlarged heart) | <input type="checkbox"/> PVD
(poor circulation/blockages) |
| <input type="checkbox"/> MI
(heart attack) | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Atrial Fibrillation
(A. Fib) | <input type="checkbox"/> AICD
(defibrillator) | <input type="checkbox"/> CEA
(clean out neck arteries) |
| <input type="checkbox"/> Coronary Angiogram
(heart cath) | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> SVT
(supraventricular tachycardia) | <input type="checkbox"/> Hypertension
(high blood pressure) | <input type="checkbox"/> Peripheral Bypass
(Leg artery bypass) |
| <input type="checkbox"/> Angioplasty
(balloon procedure) | <input type="checkbox"/> Aortic Valve
<input type="checkbox"/> Replacement
<input type="checkbox"/> Repair | <input type="checkbox"/> Bradycardia
(slow heart rate) | <input type="checkbox"/> Dyslipidemia
(abnormal cholesterol) | <input type="checkbox"/> Peripheral Stents
(leg or kidney or neck) |
| <input type="checkbox"/> Stents
(in heart) | <input type="checkbox"/> Bioprosthetic
<input type="checkbox"/> Mechanical | <input type="checkbox"/> Tachycardia
(fast heart rate) | <input type="checkbox"/> CVA
(stroke) | <input type="checkbox"/> Peripheral Angioplasty
(leg or kidney or neck balloon) |
| <input type="checkbox"/> CABG
(coronary artery bypass) | <input type="checkbox"/> Mitral Valve
<input type="checkbox"/> Replacement
<input type="checkbox"/> Repair | <input type="checkbox"/> PPM
(pacemaker) | <input type="checkbox"/> TIA
(mini-stroke) | _____ |
| <input type="checkbox"/> Diabetes
<input type="checkbox"/> Type 1
<input type="checkbox"/> Type 2 | <input type="checkbox"/> Bioprosthetic
<input type="checkbox"/> Mechanical | <input type="checkbox"/> Guidant
<input type="checkbox"/> St. Jude
<input type="checkbox"/> Other: _____ | <input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Too High
<input type="checkbox"/> Too Low | _____ |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Ablation | | | |

PAST SURGICAL HISTORY (Operations): _____

FAMILY HISTORY: *Please circle all that apply*

CAD (heart disease in family members before the age of 55) HTN (high blood pressure) HCOL (high cholesterol) CVA (stroke) DM (diabetes)
 Valvular heart disease Other: _____

SOCIAL HISTORY: *Please fill in the blanks or circle as necessary*

Tobacco Use (smoking or chewing): Yes No Never Quit _____ yrs ago After _____ yrs of use PPD
 (packs/day) _____

Alcohol Use Yes No Number of drinks per week _____ Recreational Drug Use Yes No

Occupation: _____ Living Situation: _____ Marital Status: _____

Exercise? Yes _____ No Healthy eating habits? Yes No

HEART CARE CENTER OF NORTHWEST HOUSTON, PA

IMPORTANT ITEMS TO BRING WITH YOU THE DAY OF YOUR VISIT

- COPIES OF ANY LAB WORK THAT YOU HAVE HAD DONE IN THE PAST 12 MONTHS
- COPY OF YOUR LAST ECG (ELECTROCARDIOGRAM)
- BRING ALL YOUR MEDICATION BOTTLES THAT YOU ARE CURRENTLY TAKING
- BRING YOUR PRIMARY INSURANCE CARD
- BRING YOUR SECONDARY INSURANCE CARD, IF APPLICABLE
- BE PREPARED TO PAY YOUR CO-PAY WHEN YOU CHECK IN, IF APPLICABLE
- IF YOUR PRIMARY INSURANCE PLAN REQUIRES A **REFERRAL**, PLEASE MAKE SURE YOU BRING A COPY OF THE CURRENT REFERRAL WITH YOU
- IF YOU WERE REFERRED BY YOUR PHYSICIAN FOR A DIAGNOSTIC TEST ONLY, PLEASE BRING A **COPY OF THE ORDER FORM** FROM YOUR DOCTOR THAT STATES WHAT TYPE OF SERVICE HE/SHE IS REQUESTING

THANK YOU !!!!!