Patient Name: _____ **Date of Birth:**_____

Pharmacy Name: _____**Pharmacy Address/Phone #:**_____

REVIEW OF SYSTEMS

Please circle any of the following symptoms that you are currently experiencing for your visit today:

DENY ALL OF THE BELOW (OR If nothing has changed since your last visit, check this box): ☐

Constitution	**Cardiovascular**	**Respiratory**	**Skin**
Fatigue	Chest heaviness	Cough	Changes in nail beds
Fever	Chest pain	Coughing up blood	Poor wound healing
Generalized weakness	Chest tightness	Shortness of breath	Rash
Weight gain	Edema/Leg swelling	Sleep apnea	Skin cancer
Weight loss	High blood pressure	Wheezing	
	High cholesterol		**Musculoskeletal**
HENT	Palpitations	**Endocrine**	Falls
Hoarseness		Excessive thirst	Joint pain/swelling
Nose bleeds	**Genitourinary**	Intolerance to cold	Muscle pain/weakness
	Blood in urine	Intolerance to heat	
Gastrointestinal	Painful urination		**Psychiatric**
Abdominal pain	Frequent urination	**Heme/Lymph**	Altered mental status
Blood in stool		Bleeding	Anxiety
Diarrhea	**Neurological**	Easy bruising	Depression
Stomach pain after eating	Brief paralysis	Swollen Lymph nodes	Sleep disorder
Vomiting	Dizziness		Substance abuse
Vomiting with blood	Numbness in extremities		
	Seizures		
Eyes	Vertigo		
Blurred vision			

Please explain any other symptoms not listed above that you may be experiencing:

_____

_____

Patient Name: _____ Date of Birth:_____

Pharmacy Name: _____Pharmacy Address/Phone #:_____

Medication List

Please include all prescription and over-the-counter medications, including herbal products and vitamins.
Please update the form before every physician visit and bring the form to every visit.

	Medication	Dose	How Often
example	*Metoprolol tartrate*	*25 mg*	*Twice daily*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

MEDICAL HISTORY QUESTIONNAIRE

*IF IT HAS BEEN THREE OR MORE YEARS SINCE YOUR LAST VISIT, COMPLETE THE ENTIRE FORM **IF LESS THAN THREE YEARS, PLEASE UPDATE AREAS THAT HAVE CHANGED SINCE THE LAST VISIT***

Patient Name: _____ Appointment Date:_____

Date of Birth:_____Age:_____Primary Care Doctor:_____

DO YOU HAVE A LIVING WILL OR A MEDICAL POWER OF ATTORNEY? (circle one) YES NO

HAVE YOU HAD THIS SEASON'S FLU IMMUNIZATION? (circle one) YES NO DATE_____

HAVE YOU HAD YOUR PNEUMONIA IMMUNIZATION? (circle one) YES NO DATE_____

HAVE YOU HAD YOUR COVID_19 IMMUNIZATION? (circle one) YES NO DATE_____

PAST MEDICAL HISTORY

Please check anything you have been diagnosed with in the past

PAST MEDICAL HISTORY		
○ **Aortic Aneurysm**	○ **Carotid Disease**	○ **Kidney Disease**
○ **A-Fib**	○ **Heart Failure**	○ **Heart Attack**
○ **Anemia**	○ **Clotting Disorder**	○ **Peripheral Arterial Disease**
○ **Angina**	○ **Coronary Artery Disease**	○ **Sleep Apnea**
○ **Arrhythmia**	○ **Diabetes**	○ **Stroke/TIA**
○ **Asthma**	○ **Heart Murmur**	○ **Syncope (Fainting)**
○ **Cancer**	○ **High Cholesterol**	○ **Thyroid Disease**
○ **Cardiomyopathy**	○ **High Blood Pressure**	○ **Varicose/Spider Veins**
○	○	○
OTHER MEDICAL HISTORY		
○ **Anxiety**	○ **Easy Bruising/Bleeding**	○ **Phlebitis/Swelling**
○ **Arthritis**	○ **HIV/AIDS**	○ **Rheumatic Fever**
○ **Blood Clots in Veins/Lungs**	○ **Liver Problems/Hepatitis**	○ **Stomach/Intestinal Ulcers**
○ **COPD/Emphysema**	○ **Menopause**	○ **Tuberculosis**
○ **Depression**	○	○
PAST CARDIAC SURGERIES		
○ **AAA Repair**	○ **Cardioversion**	○ **LARIAT**
○ **Cardiac Ablation**	○ **Carotid Stent**	○ **Pacemaker**
○ **ASD Repair**	○ **Coronary Stent**	○ **Peripheral Stent**
○ **Coronary Bypass**	○ **ICD**	○ **Valve Repair/Replacement**
○ **Cardiac Catheterization**	○	○
OTHER SURGICAL HISTORY		
○ **Appendectomy**	○ **Fracture Repair**	○ **Knee Replacement**
○ **Carpel Tunnel Release**	○ **Gall Bladder**	○ **Knee Surgery**
○ **Cataract**	○ **Hip Replacement**	○ **Tonsils/Adenoids**
○ **C-Section**	○ **Hysterectomy**	○ **Vasectomy/Tubal Ligation**
○	○	○
OTHER		
○	○	○

FAMILY HISTORY

Please check appropriate boxes below:

Relationship	Alive/Deceased	Arrhythmia	Coronary Artery Disease	Clotting Disorder	Diabetes	Heart Attack	Heart Disease	Heart Failure	High Cholesterol	High Blood Pressure	Stroke/TIA	Sudden Cardiac Death	Varicose Veins	Venous Insufficiency
Mother														
Father														
Sister														
Brother														
Maternal Aunt														
Maternal Uncle														
Paternal Aunt														
Paternal Uncle														
Maternal Grandmother														
Maternal Grandfather														
Paternal Grandmother														
Paternal Grandfather														

Or Circle One Below:

Adopted

Family History Unknown

SOCIAL HISTORY

Do you drink alcoholic beverages? (circle one) YES NO

How many drinks per week? ____ glasses of wine
____ cans of beer
____ shots of liquor
____ mixed drinks

Do you use illegal drugs/abuse prescription drugs? (circle one) YES NO

If yes which drugs? _____ How often? _____

Have you ever been a smoker? (choose from the below)

Never

Former; Quit date _____

Current smoker; Years smoked _____ Packs per day _____

Do you use smokeless tobacco? (choose from the below)

Never

Former; Quit date _____

Current user; Years used _____ Uses per day _____

If you smoke/use tobacco, are you ready to quit? (circle one) YES NO

Do you exercise regularly? (circle one) YES NO

Do you drink caffeine? (circle one) YES NO

ALLERGIES

Have you had a reaction to X-Ray contrast dye? (circle one) YES NO

Are you allergic to iodine or shellfish? (circle one) YES NO

Are you allergic to any medications? (circle one) YES NO

If yes, please list medication names:

Patient Registration Form

(Please print or write legibly)

Last Name: _____ First:_____MI:_____

Gender Identity: (please circle one below)
Female; Male; Transgender Female to Male; Transgender Male to Female; Choose not to disclose

Date of Birth:_____Social Security: _____

Mailing Address: _____Apt.#:_____

City:_____State: _____Zip: _____

Please check the preferred primary phone number:

☐Home Phone: (___) _____☐Work Phone: (___) _____

☐Mobile Phone: (___) _____ Email: _____

Preferred Language: _____Marital Status: _____Race/Ethnicity: _____

Emergency Contact Person:_____Relationship: _____

Primary Number: (___)_____Secondary Number: (___)_____

Primary Care Physician: _____Referring Physician: _____

Employer's Name: _____ Occupation: _____

Employer's Mailing Address: _____Suite #: _____

City: _____ State: _____ Zip: _____

Insurance

Insurance card(s) or proof of insurance must be presented at time of service.

Primary Insurance: _____Policy #: _____

Policy Holder's Name: _____Policy Holder's DOB:_____

Secondary Insurance: _____Policy #: _____

Policy Holder's Name: _____Policy Holder's DOB:_____

Tertiary Insurance: _____Policy #: _____

Policy Holder's Name: _____Policy Holder's DOB:_____

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to Heart Endovascular and Rhythm of Texas, PLLC. I understand that I am financially responsible for all charges, co-payments, co-insurance, and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

Signature of Patient or Personal Representative_____ Date: _____

Financial acknowledgement for Private Pay Patients or Patients without Insurance

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

Signature of Patient or Personal Representative_____ Date: _____

HEART ENDOVASCULAR AND RHYTHM OF TEXAS
PATIENT CONSENT FORM
General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo suggested treatments or procedures after being fully informed of the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is intended to obtain your consent to perform the evaluation necessary to identify appropriate treatments and/or procedures for any identified condition(s). The consent will remain effective in full until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you indicate that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership or contract.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. You have the right at any time to discontinue services.

I voluntarily request a Heart Endovascular and Rhythm of Texas, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Heart Endovascular and Rhythm of Texas, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	**Date**
_____	_____
Printed Name of Patient or Personal Representative	**Relationship to Patient**
_____	_____
Printed Name of Witnessing Employee	**Employee Job Title**
_____	_____
Signature of Witnessing Employee	**Date**

HEART ENDOVASCULAR AND RHYTHM OF TEXAS
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name (Printed): _____ Date of Birth: _____

Notice of Privacy Practice/clinics.

_____ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent ____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR

I do not consent ____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page). The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____. **I authorize** to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that is**_____. ***-OR***

I **decline** _____ (Patient/ Representative Initials) to receive communication via text.
I **decline** _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.
I **decline** _____ (Patient/ Representative Initials) to receive communication via email.

Note: *This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.*

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations. ·Healthcare information regarding a prior service(s) at other H.E.A.R.T. affiliated providers may be made available to subsequent H.E.A.R.T-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient ’s behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer’s designee when the services delivered are related to a claim under worker’s compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse’s notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. · Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Continued from previous page…

_____ _____

Signature of Patient/Guardian/Personal Representative **Date**

_____ _____

Printed Name of Patient/Guardian/Personal Representative **Relationship to Patient**

_____ _____

Printed Name of Patient **Date of Birth**

Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above-mentioned communications.

_____I hereby **revoke** my request to receive any future appointment reminders, feedback, and general health **via *TEXT***.

_____I hereby **revoke** my request to receive any future appointment reminders, feedback, and general **health via CELLULAR TELEPHONE CALL.**

_____I hereby **revoke** my request to receive any future appointment reminders, feedback, and general health **via EMAIL.**

Patient Name Printed: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

The form below will authorize the release of patient information TO Heart Endovascular and Rhythm of Texas (HEART) FROM another provider

Patient Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

Telephone Number(s): w=work, h=home, c=cell _____

Request Records from a provider (Be sure to complete this section to prevent delays in obtaining your records):

Name of Doctor/Provider/Organization: _____

Phone #: _____Fax #: _____

Address/City/State/Zip: _____

The following information is to be released TO Heart Endovascular and Rhythm of Texas (HEART) at fax # 512.215.8824 or via email at info@heartdoc.care

Please circle all that apply:

Entire Record	**Immunization Records**	**Laboratory Reports**	**Radiology/Imaging Reports**
Consultation	**Progress Notes**	**Most Recent History and Physical**	**Other:**

I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

Description or the purpose of the use and/or disclosure (please circle all that apply):

Continuing Care	**Second Opinion**	**Social Security/Disability**	**Personal Use**
Consultation/Referral	**Insurance**	**Legal Purposes**	**Other (please describe):**

I understand that this authorization is voluntary, and I may refuse to sign this authorization, I further understand that my health care and the payment of services rendered will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand Heart Endovascular and Rhythm of Texas has fees for the type of records provided. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. **This authorization will be in effect until_____ (date of event)**.

I understand I may revoke this authorization at any time by notifying Heart Endovascular and Rhythm of Texas. I understand that if I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Patient Signature: x_____ Printed Name of Patient: _____Date:_____

Relationship to Patient: _____Legal Authority (attach supporting documents):_____