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New Patient Packet

Name: Last _____ First _____ M.I. _____

Addresss_____

City _____ State _____Zip_____

Phone: Home _____ Cell_____ Work _____Ext____

E-mail address _____

Can we send reminders by e-mail and text? YES / NO

Male____ Female____ D.O.B._____ SOC SEC# _____-_____-_____

Student__ Retired __ Employed where _____Single __ Married __ Divorced __Widow __

Race: _____ Language spoken at home_____

Ethnicity: ___Hispanic or Latin ___not Hispanic or Latin ___prefer not to report

Spouse name_____ D.O.B._____

Emergency contact _____ Relationship_____ Phone_____

Local Pharmacy _____ Intersection/cross street _____Phone_____

Mail order Pharmacy _____Phone_____

Primary Insurance _____Phone_____

ID#_____ Group#_____

Secondary Insurance_____ Phone_____

ID#_____Group#_____

Who is your Primary Care Doctor? _____ Phone _____Fax _____

Who Referred you to us? _____Phone _____ Fax_____

Do you need a referral? **YES / NO** Do you have referral? **Yes / NO**

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Patient's Personal History

All information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your physician in decisions regarding your care.

What is your primary reason for seeing the doctor?_____-

_____

_____

_____

_____

Medication Please include all over-the-counter medications vitamins.	**Dose (mg)**	**Frequency**	**Start date (year is fine)**

Are you allergic to Iodine? Yes / No **Do you have any drug or food allergies? Yes / No**

Medication // Allergies	**Reaction**	**Year**

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PATIENT'S REVIEW OF SYSTEMS

Have you now or in the last 6 months experienced lightheadedness or dizziness? **Yes / No**
Chest pain **Yes / No** a.) with exertion? _____ b.) at rest? _____
Shortness of breath **Yes / No** a.) with exertion? _____ b.) at rest? _____
Wake from sleep because of shortness of breath? **Yes / No**
Pain or swelling in legs? **Yes / No**
Sleeplessness or tiredness **Yes / No**
Sleep with head elevated to facilitate breathing. **Yes / No**
Do you have headaches? **Yes / No**
Ringing in ears? **Yes / No**
LADIES: When was your last menstrual period? _____ Breast Implants Yes / No

PATIENT'S SOCIAL HISTORY

Have you ever smoked? **Yes / No** *Year quit or age when quit* _____
Do you currently smoke? _____ *Packs per day* _____
Do you use: _____Chewing Tobacco _____Cigar _____Pipe _____Other _____

Please specify the number of cups per day you drink of each of the following caffeinated drinks:
Coffee _____ Tea _____ Soda _____ Energy Drink_____

Do you regularly drink: **Yes / No**
Beer _____ Number of drinks per day _____Number of drinks per month_____
Wine _____ Number of drinks per day _____Number of drinks per month_____
Liquor _____ Number of drinks per day _____ Number of drinks per month_____

Have you ever had a drug problem or are you using recreational drugs now? **Yes / No**
Occupation: _____
Is there much tension or pressure in your job? **Yes / No**
Number of children: _____

List operations and serious illness.

_____Year_____
_____Year_____
_____Year_____
_____Year_____

List any Hospitalizations that you have had.

_____Year_____
_____Year_____
_____Year_____
_____Year_____

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Have <u>you</u> ever had any of the following?

PAST MEDICAL HISTORY *If any are marked yes, please specify age at onset.*		
__ Aortic Aneurysm	__ Heart Failure	__ Kidney Disease
__ A-Fib	__ Clotting Disorder	__ Heart Attack
__ Anemia	__ Coronary Artery Disease	__ Peripheral Arterial Disease
__ Angina	__ Diabetes	__ Sleep Apnea
__ Arrhythmia	__ Heart Murmur	__ Stroke / TIA
__ Asthma	__ High Cholesterol	__ Syncope (Fainting)
__ Cancer	__ High Blood Pressure	__ Thyroid Disease
__ Cardiomyopathy		__ Varicose // Spider Veins
OTHER MEDICAL HISTORY *If any are marked yes, please specify age at onset.*		
__ 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 CARDIC SURGERIES *If any are marked yes, please specify age at onset.*		
__ AAA Repair	__ Carotid Disease	__ Lariat
__ Cardiac Ablation	__ Cardioversion	__ Pacemaker(brand) _____
__ASD repair	__ Carotid Stent	__ Peripheral Stent
__ Coronary Bypass	__ Coronary Stent	__ Valve repair / replacement
__Cardiac Catheterization	__ ICD (brand)_____	__ _____

Has anyone in your immediate family ever had the following?

	Congestive Heart Failure	Congenital Heart Disease	Diabetes	High Blood Pressure	High Cholesterol	Heart Attack	Heart Murmur	Stroke
Mother								
Maternal Grandmother								
Maternal Grandfather								
Maternal Aunt / Uncle								
Father								
Paternal Grandmother								
Paternal Grandfather								
Paternal Aunt / Uncle								
Sibling								
Sibling								
Sibling								

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Please Check *all symptoms that you are having.*

Cardiovascular

__ Murmur
__ Irregular heart Rhythm
__ Palpitations
__ Squeezing of the chest
__ Chest Pain
__ Chest tightness or discomfort
__ Shortness of breath
__ Shortness of breath w/ Exertion

Ears Nose

__ Hearing Loss
__ Ringing in ears
__ Abnormal mucous membranes

Eyes

__ blurred or Double vision
__ Contacts or glasses

Gastrointestinal

__ Abdominal Pain
__ Weight Gain
__ Weight Loss
__ Change in appetite
__ Nausea or Vomiting
__ Diarrhea or Constipation
__ Indigestion or Heartburn
__ Reflux

Genitourinary

__ Incontinence
__ Frequent Urination
__ Blood in Urine
__ Pain or burning with urination

Integumentary

__ Edema (swelling)
__Sweating
__Bruising
__ Skin Lesions
__Skin Cancer
__Rash or itching on skin

Musculoskeletal

__ Arthritis
__ Back or Neck Pain
__ Leg Pain
__ Arm Pain
__ Gout

Neurological

__ Gait Disturbances (trouble walking)
__ Seizures
__ Confusion or Memory Loss
__ Weakness or Fatigue
__ Numbness or Tingling
__ Headaches
__ Dizziness
__ Syncope (Passed out)
__ Swallowing Difficulties
__ Difficulties in Speech

Psychiatric

__ Anxiety Problems
__ Depressive Symptoms
__ Personality or Mood Changes

Respiratory

__ Congestion or Wheezing
__ Cough

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Authorization for Release of Medical Records

*(from another facility to **Advacardio**)*

Patient Name: _____ Birth Date: _____ Social Security Number: _____

(Please list all Doctors and Hospitals we need to get records from)

Name _____Phone_____ Fax_____

Name _____Phone_____ Fax_____

Name _____Phone_____ Fax_____

To release all the information contained in my medical records to:

ADVACARDIO
Dr. Kozhaya C. Sokhon,
Phone: 281-533-5333
Fax: 281-533-5335

*The information being released will only be used for medical purposes.
*This authorization is valid for one year from the date of signing.
*The patient or his/her representative may revoke this consent at any time.

By signing this form, I _____ authorize the release of confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the **person(s) or entity** listed above.

*_____

Patient Signature [or parent, guardian, or legal representative]

PROHIBITION OF REDISCLOSURE: This information is being disclosed from medical records whose confidentiality is protected by law. Any further disclosure of this information must be by written consent of the person to whom it pertains. A general authorization for release of medical other information if held by another party is not sufficient for this purpose. The party to whom this consent is addressed releases this information by reason of the signature noted above and is not responsible for redisclosure for any purpose.

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Authorization Form for Release of Protected Health Information

Patient Name: _____ DOB _____

Below please list any family member or Physicians we may share your medical information with.

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** **Date:**

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following: **Advacardio 25329 Interstate 45, The Woodlands TX 77380**

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____

Name of Patient or Personal Representative Date

_____ _____

Signature of Patient or Personal Representative: Date

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Signature on File

☐ Medicare

I hereby request that payment of authorized **Medicare benefits** be made on my behalf to Advacardio and/or Dr. Sokhon for any services furnished me by the company listed. I authorize any holder of medical information about me to release to **Medicare** and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determined of the Medicare Carrier as the full charge, and the patient is responsible for only the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Commercial Insurance and/or Medicare Carrier.

☐ Commercial Insurance

I request that payment of authorized **Commercial Insurance** be made on my behalf to Advacardio and/or Dr. Sokhon for any services furnished me by the company listed. I authorize any holder of medical information about me to release to **Commercial Insurance** and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Block 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determined of the Medicare Carrier as the full charge, and the patient is responsible for only the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Commercial Insurance and/or Medicare Carrier.

Patient's Printed Name: _____Date_____

Patient's Signature: _____Date _____

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Financial Responsibility

Patient Name: _____ Date _____

Thank you for choosing Advacardio for your medical needs. We are committed to providing you the best care available. We ask that all responsible parties read and sign our financial policy. If you have any questions, please feel free to ask our staff to discuss any fees or this policy with you.

As the responsible party, please understand:

1. Advacardio will bill your insurance company on your behalf; however, you are ultimately responsible for the bill.
2. You are financially responsible for any balance not covered by your insurance plan.
3. Co-payments, Co-Insurance and Deductible are due at the time of your visit.
4. You are required to pay your potion of any Surgery/Procedure prior to the procedure date. Advacardio will provide you with an estimate of your responsibility when possible and a date which payment is due. We will work with you to set up a payment plan if needed.
5. Please inform the front desk/office of any changes in your address, phone number and Insurance immediately.
6. You are responsible for providing a referral from your Primary Care Physician should your insurance require one. If your insurance company denies payment due to Non-Referral, you, the patient agree to pay Advacardio in full for nay charges incurred during the visit.
7. In the event that a check is returned, you are responsible for the amount of the check plus $25 bank fees.
8. The completion of disability and /or FMLA forms can take up to 2 weeks. Advacardio charges $15 to complete these forms.
9. Medical Records are Free of charge if Faxed or Sent directly to Licensed Provider. Complete Medical Records
   that need to be printed will be charged according to the rulings set forth by the Texas State Board of Medical Examiners.
10. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly **"full"** schedule. **If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 fee; this will not be covered by your insurance company.**

Patient's Signature _____ Date _____