PARTO
HEART & VASCULAR

Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last)_____(First)_____(MI) _____ Previous Name _____

Address Line 1 _____

City, State_____ZIP _____

Home Phone_____Cell No._____Work Phone_____Ext._____

E-Mail Address:_____

Date of Birth MM_____/DD_____/YYYY_____ Sex ☐ Female ☐ Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Primary Care Physician_____ How did you hear about us? _____

Emergency Contact: _____. Phone Number_____

Emergency Contact Relationship to Patient_____ ☐ Guardian

Address Line 1 _____

City, State_____ ZIP _____

Home Phone_____Work Phone_____Ext.

Do you have a living will? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last)_____(First)_____ (MI)_____

Guarantor Account Number_____Date of Birth MM_____/DD_____/YYYY_____

Social Security Number_____-_____-_____Telephone _____

E -Mail Address_____Sex ☐ Female ☐ Male

Address Line 1 _____

City, State_____ZIP _____

Employer_____ Employer Phone Number_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____(_____)_____

Name of Insured_____Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____Group ID_____Copay Amount_____ Effective Date_____Termination Date_____Date of Birth MM__/DD____/YYYY

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____(_____)_____

Name of Insured_____Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____Group ID_____Copay Amount_____

Effective Date_____Termination Date_____Date of Birth MM_____/DD_____/YYYY

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

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Name:_____

Pharmacy Name:_____ **Pharmacy Number:**_____

Do you have or have you been treated for: (Circle all that apply)

Chest Pain Heart Attack High Blood Pressure High Cholesterol Diabetes Stroke COPD

Carotid Disease Heart Failure Heart Valve Problem Heart Murmur Rheumatic Fever

Heart Rhythm Problem Vascular Disease Asthma Tuberculosis Anemia Blood Disorder

Stomach Ulcer Heartburn/Reflux Thyroid Problem Kidney Disease Gallbladder

Hepatitis Arthritis Sleep Apnea Seizures Cancer date:_____ Site: _____

Other _____

Please List Surgeries: (Give location and date)

_____

_____

Have you ever had any of the following heart tests? (Give location and date)

Cardiac Catheterization_____ Stress Test (exercise test): _____

Echocardiogram:_____ Stress Echocardiogram: _____

Nuclear Stress Test:_____ Holter Monitor (24/48 hrs.) or Event Monitor (30 days):_____

Habits: Do you smoke? ☐ Yes ☐No How many years?_____ Packs Daily:_____Interested in quitting? ☐ Yes ☐No
Did you ever smoke? ☐ Yes ☐No How many years?_____ Packs Daily:_____When did you quit?_____
How much alcohol do you drink?_____ day_____week_____month_____year
How many caffeinated drinks do you drink? (Coffee, tea, soda)_____day_____week

Are you **allergic** to any medications? ☐ Yes ☐No, please list: _____

Circle all that you are allergic to: Dye used for X-rays (IV dye) Adhesive Tape Latex Shell Fish

Family History Living		Age	Heart Problem	High Blood Pressure	High Cholesterol	Stroke	Diabetes	Cancer
Father	☐Y ☐N	_____	☐	☐	☐	☐	☐	☐
Mother	☐Y ☐N	_____	☐	☐	☐	☐	☐	☐
Brother(s)	☐Y ☐N	_____	☐	☐	☐	☐	☐	☐
Sister(s)	☐Y ☐N	_____	☐	☐	☐	☐	☐	☐
Paternal Grandpa	☐Y ☐N	_____	☐	☐	☐	☐	☐	☐
Paternal Grandma	☐Y ☐N	_____	☐	☐	☐	☐	☐	☐
Maternal Grandpa	☐Y ☐N	_____	☐	☐	☐	☐	☐	☐
Maternal Grandma	☐Y ☐N	_____	☐	☐	☐	☐	☐	☐

Name: _____ Date of Birth: _____ Date: _____

Medications:

include vitamins, herbal supplements, and over the counter mediations

Name	Dose	How many times a day?

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Patient HIPAA Acknowledgement and Consent Form

Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practices/clinics

_____ **(Patient/Representative initials)** I acknowledge that I have received the practice's Notice of Privacy Practice, which describes the ways in which the practice 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's Notice of Privacy Practice.

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
1.			
2.			
3.			

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

Communication about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

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

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the practice 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.

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

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. 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).

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 and the physician 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 affiliated providers may be made available to subsequent 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.

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

Patient/Representative Signature	**Relationship to Patient (self, parent, legal guardian/representative, etc)**	**Date**

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- **I do want _____** (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

	Name	**Relationship**	**Contact Number**
1.			

- **I do not want _____** (Patient/Representative Initials) to designate anyone to pick-up my prescription order.

_____ _____

Signature of Patient/Representative Date