Premier
Cardiovascular Care
of Dallas

TYPE OF VISIT:
☐ **New Patient** ☐ **Work Comp** ☐ **Auto** ☐ **Other**

PATIENT INFORMATION
(Please Print)

Primary Care Physician: _____

Co-Pay $_____ Referring Physician: _____

Name: _____ Date of Birth: _____ Age: _____
(Last) (First) (Initial)

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Soc. Sec. #: _____

Emergency Contact Person: _____ Relation: _____ Phone: _____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Ethnicity: ☐ Hispanic ☐ Latino ☐ Not Hispanic or Latino

☐ Full time ☐ Part time ☐ Retired ☐ Disabled ☐ Unemployed

Employer: _____ Work Phone: _____

If you are not the primary insurance holder, please complete below.

Primary Insured Name: _____ Relationship to Patient: _____ DOB: _____

OUR OFFICE HAS AN AUTOMATED MESSAGE SYSTEM THAT WILL NOTIFY YOU OF YOUR APPOINTMENTS AND ONCE YOUR REFILL REQUEST IS PROCESSED.

Besides regular mail, I authorize Premier to contact me by the following methods:

☐ **Cell phone** ☐ **Text messaging** ☐ **Home phone** ☐ **Email**

SIGN: _____ **DATE:** _____

☐ **OK to leave detailed message**

Does this visit pertain to a workers' compensation injury or a personal injury? ☐ **No** ☐ **Yes, If yes,**

Date of Injury: _____ Claim #: _____ Adjuster Name: _____ Phone Number: _____

Is there a lawsuit planned, relating to your problem or injury, whether it be from a workers' compensation claim or motor vehicle accident? ☐ ***No*** ☐ ***Yes***

PATIENT NAME: _____ DATE: _____

RELEASE OF INFORMATION TO OTHERS (HIPAA)

I acknowledge that I have received a copy of Notice of Privacy Practices. I authorize Premier Cardiovascular Care of Dallas and its staff to use and disclose the protected health information described below, to the individuals named. These individuals may also pick up prescriptions, medical records and other health related items on my behalf.

What level of information can we release?

☐ All information including specific medications and dosages, lab results and information related to sensitive issues such as sexually transmitted diseases (including but not limited to AIDS and Hepatitis C).

☐ **No information whatsoever**

To whom can we release information (please list names):

☐ _____
Name Phone # Relationship to Patient

☐ _____
Name Phone # Relationship to Patient

☐ _____
Primary Care Physician Name Phone #

☐ **No one except the patient can obtain information.**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing that the revocation will not apply to information already released in response to this authorization.

2. _____ _____
Signature of Patient/Guardian Date

TREATMENT CONSENT AND AUTHORIZATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment and is a means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill and a means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I hereby authorize Premier Cardiovascular Care of Dallas. To furnish to any designated attorney or insurance company all information necessary to file a health insurance claim form, or to obtain reimbursement. *I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Premier Cardiovascular Care of Dallas*. I understand that I am financially responsible for all changes whether paid or not paid by my insurance company. Also, I hereby authorize the disclosure of health information in any data format regarding my treatment during hospitalization and/or outpatient care to Premier Cardiovascular Care of Dallas. I understand that this facility will maintain medical records in accordance with state requirements. By my signature below, you are fully authorized to disclose such information when requested by Premier Cardiovascular Care of Dallas.

The foregoing information is true and correct to the best of my knowledge. I authoize Premier Cardiovascular Care of Dallas to provide medical treatment to me in the office or in the hospital.

3. _____ _____
Signature of Patient/Guardian Date

FINANCIAL AND GENERAL POLICY SIGNATURE

I have read and understand the Premier Cardiovascular Care of Dallas Financial and General Office Policies. My signature indicates compliance and understanding of these policies and that I have completed all the forms to the best of my knowledge.

4. _____ _____
Signature of Patient/Guardian Date

PATIENT NAME: _____ DATE: _____

REASON FOR VISIT

PLEASE TELL US THE REASON FOR YOUR VISIT: _____

_____

_____

PHARMACY INFORMATION

PREFERRED PHARMACY: _____ PHONE #: _____

PHARMACY ADDRESS: _____

MEDICATION ALLERGIES

☐ **No known Drug Allergies**

☐ **No Other Allergies (latex, contrast or adhesives)**

☐ **Yes I have known Drug Allergies (Please list name and symptoms)**

1. _____ _____

2. _____ _____

☐ **Yes I have Other Allergies to things like latex, contrast or adhesives (Please list name and symptoms)**

1. _____ _____

2. _____

CURRENT MEDICATIONS

LIST ALL THE CURRENT MEDICATIONS YOU ARE TAKING

NAME:	**DOSE**	**FREQUENCY**	**REASON PRESCRIBED:**
Example: Benadryl	*40 mg*	*one tab a day*	*Allergies*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

I understand that prescription refills should be handled at the time of the office visit whenever possible. It is my responsibility to know when my prescription is about to run out. A good rule of thumb is to always have at least a three day supply on hand. Medication refills are only handled during regular business hours and will not be addressed after business hours or on weekends.

6. _____ _____

Signature of Patient/Guardian Date

PATIENT NAME: _____ DATE: _____

REVIEW OF SYSTEMS AND PAST FAMILY SOCIAL HISTORY

ROS. Does the patient currently have any of these issues? *Please circle yes or no*

Constitutional	Fatigue	No	Yes	Fever/Chills	No	Yes	Weight Loss/Gain	No	Yes
Neurologic	Seizures	No	Yes	Dizziness/Vertigo	No	Yes	Headaches	No	Yes
Musculoskeletal	Joint Pain	No	Yes	Back/Neck Pain	No	Yes	Morning Stiffness	No	Yes
Skin	Rash	No	Yes	Ulcers/Lesions	No	Yes			
Pulmonary	Short of Breath	No	Yes	Wheezing	No	Yes	Cough	No	Yes
Cardiology	Chest Pain	No	Yes	Palpitations	No	Yes	Irregular Heart Beat	No	Yes
	Swelling	No	Yes						
Gastrointestinal	Diarrhea	No	Yes	Nausea/Vomiting	No	Yes	Abd Pain/Blood in Stool	No	Yes
Genitourinary	Freq Urine	No	Yes	Pain Urinating	No	Yes	Burning with Urination	No	Yes
Eyes / Ears / Nose	Nasal Drainage	No	Yes	Change of Vision	No	Yes	Loss of Hearing	No	Yes
Mouth and Throat	Sore Throat	No	Yes	Tooth Ache	No	Yes			
Hematologic	Easy Bleeding	No	Yes	Easy Bruising	No	Yes			
Psychiatric	Anxiety	No	Yes	Depression	No	Yes			

If you checked yes to any of the above, are you under treatment for this issue with a physician? ☐ No ☐ Yes

If so, who is the physician treating you?_____

FAMILY AND SOCIAL HISTORY

☐ **Right Handed** ☐ **Left Handed** ☐ **Height** _____ ☐ **Weight** _____

Alcohol Intake:

Please circle the one that applies to you: Never Drink Drink Occasionally Drink Daily

Please circle what you drink: Wine Beer Liquor

Does any family members have an alcohol history? ☐ No ☐ Yes

Smoking History:

Do you smoke currently? ☐ No ☐ Yes How long?_____ How many?_____ packs/day

Are you a former smoker? ☐ No ☐ Yes When did you quit?_____

How many years did you smoke?_____ years

Blood Products/Transfusions:

Do you have any objections to receiving blood or blood products? ☐ No ☐ Yes

Drug Usage:

Do you now or have you ever used drugs? ☐ No ☐ Yes

If yes, please explain: _____