

Alabama Heart & Vascular Medicine

New Patient Information Form

DATE: _____

ACCT NUMBER: _____

Patient Name: _____
(First) (Middle) (Last)

Date of Birth: _____ Age: _____ Marital Status: Married/Single/Widowed/Divorced

Mailing Address: _____
(Street) (City) (Zip Code)

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____ Male/Female Social Security No: _____

Did another physician refer you here? Y/N Referring Physician: _____

Who is your family physician: _____

Language: English/Spanish/Other Race: _____ Ethnicity: Nonhispanic/Hispanic
(Circle)

Employed: Yes/No/Retired Employer: _____

Pharmacy Name: _____ Phone No: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Effective Date: _____
Contract Number: _____ Group Number: _____
Insured's Name: _____ Insured's DOB: _____

Patient's relation to insured party: Self/Spouse/Parent/Child/Other Male/Female

Secondary Insurance Name: _____ Effective Date: _____
Contract Number: _____ Group Number: _____
Insured's Name: _____ Insured's DOB: _____

Patient's relation to insured party: Self/Spouse/Parent/Child/Other Male/Female

Please have your Driver's License and all Insurance Cards available for us to scan. Thank you.

Who can we contact in case of an emergency?
Name: _____ Phone: _____ Relation: _____

I hereby authorize Alabama Heart & Vascular Medicine to release any medical information needed by my insurance carriers in order to process my claim. I hereby authorize payments direct to Alabama Heart & Vascular Medicine. I understand that it is my responsibility to provide correct insurance information to Alabama Heart & Vascular Medicine. **I understand that my insurance may not pay the bill and that some services may be considered "noncovered or not medically necessary" by my insurance contract. I understand that I will be responsible for the balance of my account.**

Patient's Signature (Agreement to Pay) Date: _____

Guarantor's Signature (Agreement to Pay) Date: _____

Alabama Heart & Vascular Medicine

G. Phil Hemstreet, M.D.,

Bradley Titus, M.D.

Dana L. Hemstreet, CRNP

Jeremy A. Kelley, CRNP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Alabama Heart & Vascular Medicine's Notice of Privacy Practices.

Please Print Name

Patient or Responsible Party Signature

Date Signed

Consent to Release Information

I (the patient or responsible party) hereby authorize Alabama Heart & Vascular Medicine, its physicians, agents, employees, or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc. to the person(s) listed below.

____ Spouse Name: _____

____ Parent(s) Name(s): _____

____ Child/Children Name(s): _____

____ Other: Name(s): _____

Alabama Heart and Vascular Medicine
Authorization to Release or to Obtain Medical Information

Patient Name (print): _____ DOB: ____/____/____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

I, the undersigned, authorize and request **Alabama Heart and Vascular Medicine** to ____ **release or to**
____ **obtain medical information from the following:**

Physician/Organization/Individual(s): _____
Address: _____ Phone: _____ Fax: _____

____ DCH Regional Medical Center or Northport Medical Center, 809 University Blvd., Tuscaloosa or 2700
Hospital Drive, Northport, AL, 205-759-7111 or 205-333-4500

Or other Hospital(s): _____
Address: _____ Phone: _____ Fax: _____

Please identify the information to be released/obtained:

____ Complete Record
____ *Lab Results (specify)* _____
____ *X-Ray/Imaging (specify)* _____
____ *Other (specify)* _____

The identified information will be used for the following purposes:

____ Sharing with my other healthcare providers
____ *For my personal records*
____ *Moving*
____ *Other (specify)* _____

Please initial each item below to indicate your understanding:

____ I understand the information in my health record may include information relating to STD's, AIDS, or HIV. It may also include information relating to behavioral or mental health services, and treatment for drug and alcohol abuse.

____ When my information is used or disclosed pursuant this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization at any time in writing and understand my revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

Patient Signature: _____ Date: ____/____/____

Relationship to Patient: ____ Parent, ____ Legal Guardian, ____ Other (please specify) _____

Witness Signature: _____ Date: ____/____/____

This authorization will expire on (insert date or event): _____

If I do not specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

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

Please check and add details out to the side

PAST MEDICAL HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Murmur |
| <input type="checkbox"/> Aneurysm: abdominal | <input type="checkbox"/> Irregular heart rhythm |
| <input type="checkbox"/> Aneurysm: Thoracic | <input type="checkbox"/> MVP (mitral valve prolapse) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> PAH (Pulmonary Artery Hypertension) |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Atrial Flutter | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> PUD (peptic ulcer disease) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> PVD (peripheral vascular disease) |
| <input type="checkbox"/> Claudication | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Renal Insufficiency |
| <input type="checkbox"/> Connective Tissue Disease (Lupus, Sarcoidosis, etc.) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> COPD (chronic obstructive pulmonary disease) | <input type="checkbox"/> Rheumatic heart disease |
| <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> SVT (supraventricular tachycardia) |
| <input type="checkbox"/> Diabetes (insulin or non-insulin dependent) | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> TB (tuberculosis) |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Gastrointestinal Bleed | <input type="checkbox"/> TIA (transient ischemic attack) |
| <input type="checkbox"/> Gastroesophageal reflux disease (GERD) | <input type="checkbox"/> Valvular Heart Disease |
| <input type="checkbox"/> Heart block | <input type="checkbox"/> Ventricular Tachycardia |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lipid disorder | |

SURGICAL HISTORY

Please check and list dates/facility/surgeon

- | | |
|--|---|
| <input type="checkbox"/> Abdominal surgery _____ | <input type="checkbox"/> Gallbladder surgery |
| <input type="checkbox"/> Amputation: above knee | <input type="checkbox"/> Heart cath (dye test) |
| <input type="checkbox"/> Amputation: below knee | <input type="checkbox"/> ICD (Defibrillator) |
| <input type="checkbox"/> Anesthesia problems | <input type="checkbox"/> ICD: BI-V |
| <input type="checkbox"/> Aneurysm Repair | <input type="checkbox"/> Mitral Valve Repair |
| <input type="checkbox"/> Aortic Valve Repair | <input type="checkbox"/> Mitral Valve Replacement |
| <input type="checkbox"/> Aortic Valve Replacement | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> PTCA/Angioplasty/stent) heart |
| <input type="checkbox"/> Arteriogram: ___Carotid___Legs___Kidneys | <input type="checkbox"/> PTCA (Angioplasty/stent) leg ___Kidney |
| <input type="checkbox"/> Bypass: Aorta-femoral: ___left___right | <input type="checkbox"/> Stent: ___Aorta___Carotid___Iliac |
| <input type="checkbox"/> Bypass: Fem-pop ___left___right | <input type="checkbox"/> Surgical Complications |
| <input type="checkbox"/> CABG (open heart) | <input type="checkbox"/> Thyroid Surgery |
| <input type="checkbox"/> Congenital heart surgery | <input type="checkbox"/> Other operations: |
| <input type="checkbox"/> Endarterectomy ___Lt carotid___Rt carotid | _____ |
| <input type="checkbox"/> EPS (Electrophysiology Study) | _____ |
| <input type="checkbox"/> MI (heart attack) | _____ |

Patient Name: _____ Date: _____

Home Medications:

List all medications & dosage you are presently taking and how frequently you take them:

Medication/Dose/Frequency:

Please list all known allergies:

FAMILY HISTORY

Please check box and circle the family member

- Aortic Aneurysm [father, mother, sibling, grandparent]
- Asthma [father, mother, sibling, grandparent]
- Bleeding Disorder [father, mother, sibling, grandparent]
- Cancer _____ [father, mother, sibling, grandparent]
- Congestive Heart Failure [father, mother, sibling, grandparent]
- Connective Tissue Disease [father, mother, sibling, grandparent]
- Coronary Artery Disease [father, mother, sibling, grandparent]
- Coronary Heart Disease – male < 55 [father, mother, sibling, grandparent]
- Coronary Heart disease – female < 55 [father, mother, sibling, grandparent]
- CVA or stroke [father, mother, sibling, grandparent]
- Diabetes [father, mother, sibling, grandparent]
- Hyperlipidemia [father, mother, sibling, grandparent]
- Hypertension [father, mother, sibling, grandparent]
- Marfan’s Syndrome [father, mother, sibling, grandparent]
- Pulmonary Artery Hypertension [father, mother, sibling, grandparent]
- Peripheral vascular disease [father, mother, sibling, grandparent]
- Prolonged QT [father, mother, sibling, grandparent]
- Renal Disease [father, mother, sibling, grandparent]
- Sudden Cardiac Death [father, mother, sibling, grandparent]
- Thyroid Disease [father, mother, sibling, grandparent]

Mother living? Yes No Age at death _____ Father living? Yes No
Age at death _____ Number of living brother & sisters _____ Number of
deceased brothers & sisters _____

SOCIAL HISTORY

Marital Status: Single/Married/Divorced/Widowed

How many children do you have? _____

What is your occupation: _____

Disabled Retired

Smoking History:

Current Smoker: year started _____

Cigarettes: _____ packs per day

Cigars: _____ number per day

Smokeless: _____ amount per day

Counseled to quit or cut down: Yes No

Former Smoker: year quit _____

Never smoked:

Passive smoke exposure: Yes No

Do you drink alcoholic beverages? Yes No

Types of Alcohol? _____

How many drinks per day? _____

Drug Use? Yes No (If yes circle type below)
Marijuana, cocaine, crack, heroin, illicit prescription
Other: _____

Do you drink caffeinated drinks? Yes No

How many per day? _____

Do you drink diet drinks? Yes No

Are you on a special diet? Yes No

Calorie Limited Low Salt

Low Fat Diabetic

High Fiber Low Cholesterol

Other _____

Do you exercise on a regular basis? Yes No

How many times per week? _____

Type of exercise? _____

Do you have a barrier to communication? Yes No

High Risk Behavior? Yes No

Comments: _____

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

Review of Systems (please check if you have any of the following)

General

- Daytime sleepiness
- Weakness
- Weight Gain
- Weight Loss

Cardiovascular

- Chest pain
- Fainting
- Heart racing (palpitations)
- Swelling in feet/legs (peripheral)

Respiratory

- Cough
- Excessive snoring
- Shortness of breath
- Wheezing

Neurologic

- Dizziness (lightheadedness)
- Morning headaches

Gastro-Intestinal

- Constipation
- Diarrhea
- Bloody stools
- Indigestion
- Dark tarry stools
- Nausea/Vomiting

Genital-Urinary

- Difficult urination (dysuria)
- Blood in urine (hematuria)

Musculo-Skeletal

- Leg pain
- Muscle cramps

Dermatologic

- Non-healing ulcer
- Scar to chest
- Scar to leg

Ears, Nose, Throat

- Hoarseness
- Nosebleed

Psychiatric

- Anxiety
- Depression

Allergies

- Allergic to Iodine
- Allergic to medications
- Allergic to shellfish
- Allergic to dye

Form Completed by: _____

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

Vascular Screening

History

Varicose veins are large, bulging veins, as opposed to spider veins, which are thin, branching veins just beneath the skin's surface. Have you ever had varicose veins? _____

Signs and Symptoms

Do you experience any of the following signs and symptoms in your legs or ankles?

Leg pain, aching or cramping _____

Burning or itching of the skin _____

Leg or ankle swelling, especially at the end of the day _____

A feeling of heaviness in legs _____

Pain from prolonged sitting or standing _____

Skin discoloration or texture changes, such as above the inner ankle _____

Open wounds or sores, such as above the inner ankle _____

Restless legs _____

Risk Factors

Has anyone in your blood-related family ever had varicose veins or been diagnosed with chronic venous insufficiency or venous reflux? Yes _____ No _____

Have you had a blood clot in a vein that cause inflammation, pain, or irritation? Yes _____ No _____

Do you have ropey veins or veins that are raised above the skin in your legs? Yes _____ No _____

Have you had any treatments or procedures for vein problems? Yes _____ No _____

Do you stand for long periods of time, such as at work? Yes _____ No _____

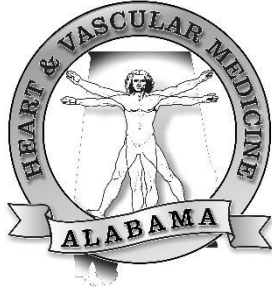
Do you suffer from tingling, numbness, burning or cramping in legs or feet? Yes _____ No _____

Do you frequently engage in heavy lifting? Yes _____ No _____

Do you have skin discoloration on your lower legs? Yes _____ No _____

Do you have hard to heal ulcers or sores on your lower legs? Yes _____ No _____

If female, have you ever been pregnant? Yes _____ No _____



ALABAMA HEART & VASCULAR MEDICINE

PHONE MESSAGE CONSENT FORM

Your physician(s) and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL NOT:

- LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT OR LEGAL GUARDIAN.
- LEAVE INFORMATION ON AN ANSWERING MACHINE
- LEAVE INFORMATION ON A VOICEMAIL

Please read below and consider carefully whom you want to have access to your medical information.

I _____ give Alabama Heart & Vascular Medicine my permission to leave phones messages regarding my medical care and test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.

My cell phones: (____)____-____ initials: _____

My home answering machine/voicemail: (____)____-____ initials: _____

My office/work voicemail: (____)____-____ initials: _____

My medical care may be discussed with the following:

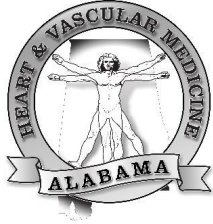
My spouse: _____ at (____)____-____ initials: _____

Other: _____ at (____)____-____ initials: _____

I DO NOT WANT MY INFORMATION LEFT ON VOICEMAIL

Patient/Guardian Signature

Date



Alabama Heart & Vascular Medicine

No Show Policy

Due to the negative impact that NO SHOWS have on our schedule we have developed a NO SHOW policy. In order to better serve you and our other patients we now require a minimum of a 24-hour cancellation notice if you will be unable to attend your scheduled appointment on time.

By signing this document, you are acknowledging that you understand and agree to our NO SHOW terms and fees.

If you fail to notify our office 24 hours prior to your scheduled appointment, your account will be subject to a \$50.00 No Show Fee that will have to be paid before your appointment will be rescheduled. If you are scheduled for a nuclear stress test and fail to notify our office 24 hours prior to your scheduled appointment your account will be subject to the full cost of the medication which is \$250.00.

If you routinely miss three appointments in a year, then you will be subject to dismissal from our practice.

**The only exceptions to this policy will be made in cases of true emergencies. **

Thank you!

Patient Name: _____

Patient Signature: _____ Date: _____



Alabama Heart & Vascular Medicine

Photo Policy

I consent that a statement/interview, and/or photograph, and/or illustration, and/or video, and/or audio recording may be taken of me by Bama Heart Doc, P.C., d/b/a Alabama Heart and Vascular Medicine (“Alabama Heart & Vascular Medicine”) regarding my personal and medical history, condition(s), and treatment(s) for the purposes of documentation, education, publication, promotion, marketing, or advertising activities, programs, and services.

I consent and grant permission to Alabama Heart and Vascular Medicine to the use of any such statement/interview, and/or photograph, and/or illustration, and/or video, and/or audio recording, including but not limited to images representing and depicting the treatment provided to me and the effect thereof, which may include Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA), by Alabama Heart & Vascular Medicine for any lawful use Alabama Heart and Vascular Medicine deems appropriate, including for treatment, advertising his/her/its services to the general public (including via social media and electronic media), illustration, and publication to the public at large for educational, promotional, advertising, or marketing purposes. I understand that I am entitled to no consideration, remuneration or payment for the use of my image in any advertising, promotional or educational materials.

I understand any image or likeness of me may be altered prior to use if deemed appropriate by Alabama Heart and Vascular Medicine. I understand and agree that I have no right to be consulted about or approve of any such alterations before my image is used.

I understand that Alabama Heart and Vascular Medicine will make all reasonable efforts to safeguard my privacy as required by applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the extent possible. I understand that Alabama Heart and Vascular Medicine cannot guarantee my complete privacy in the event my image or likeness is used by third parties.

I understand and agree that Alabama Heart and Vascular Medicine may use information regarding my health condition, including information regarding my diagnosis, course of treatment, my age, and my other relevant medical conditions, in describing the treatment rendered to me as depicted in any image of me.

I understand that Alabama Heart and Vascular Medicine may not and has not conditioned the rendition of treatment to me upon my authorization of the use of my image and/or likeness. I have read the foregoing in its entirety and understand its terms.

Print Patient Name

Signature of Patient

Date