ALABAMA HEART & VASCULAR MEDICINE

PATIENT INFORMATION

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" by my insurance contract. I understand that I will be responsible for the balance of my account.**

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

Alabama Heart & Vascular Medicine

G. Phil Hemstreet, 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, it's 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): _____

_____ _____

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

Please check and add details out to the side

PAST MEDICAL HISTORY

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

SURGICAL HISTORY

Please check and list dates/facility/surgeon

- ☐ Abdominal surgery _____
- ☐ Amputation: above knee
- ☐ Amputation: below knee
- ☐ Anesthesia problems
- ☐ Aneurysm Repair
- ☐ Aortic Valve Repair
- ☐ Aortic Valve Replacement
- ☐ Appendectomy
- ☐ Arteriogram: ___ Carotid ___ Legs ___ Kidneys
- ☐ Bypass: Aorta-femoral: ___ left ___ right
- ☐ Bypass: Fem-pop ___ left ___ right
- ☐ CABG (open heart)
- ☐ Congenital heart surgery
- ☐ Endarterectomy ___ Lt carotid ___ Rt carotid
- ☐ EPS (Electrophysiology Study)
- ☐ MI (heart attack)
- ☐ Gallbladder surgery
- ☐ Heart cath (dye test)
- ☐ ICD (Defibrillator)
- ☐ ICD: BI-V
- ☐ Mitral Valve Repair
- ☐ Mitral Valve Replacement
- ☐ Pacemaker
- ☐ PTCA/Angioplasty/stent) heart
- ☐ PTCA (Angioplasty/stent) leg ____ Kidney
- ☐ Stent: ___ Aorta ___ Carotid ___ Iliac
- ☐ Surgical Complications
- ☐ Thyroid Surgery
- ☐ Other operations:

_____

_____

_____

_____

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 and add any details out to the side

- ☐ 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

Self-Assessment & Screening

History

Have you ever had varicose veins?

-Varicose veins are large, bulging veins, as opposed to spider veins, which are thin, branching veins just beneath the skin's surface.

Yes No

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
- "Heavy" feeling in legs
- Varicose veins
- 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 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 frequently engage in heavy lifting?

Yes No

Have you ever been pregnant?

Yes No

Name_____ Date_____ Primary Physician_____

I would like to be contacted for further venous assessment? 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

G. Phil Hemstreet, MD
Jeremy Kelley, CRNP
Dana Hemstreet, CRNP
(205) 561-2370

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 scheduled. 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.

**Exceptions to this policy will be made in cases of true emergencies. **

Thank you!

Patient Name:

_____

Patient Signature: _____

Date:_____