



FOR OFFICE USE ONLY
Acct # _____

Today's Date: _____

Patient Information

Full Name: Last				First				Middle				(Maiden)					
Address: (Street or Box)						City						State				Zip	
Home Phone # () () ()				Work Phone # () () ()				Cell Phone # () () ()				Email Address					
Sex (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female				Date of Birth				Age				Social Security #				Drivers License #	
Occupation				Employer				Employer Address									
Marital Status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated						Spouse's Name				Race (check one) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Other							
If Student, Indicate School				If Patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation required):													
Emergency Contact (not living at same address)								Emergency Contact Phone # () () ()									
How did you hear about the physician you are seeing today? <input type="checkbox"/> Physician Referral (5) Who? _____ <input type="checkbox"/> Other Professional (6) <input type="checkbox"/> Existing Patient (10) <input type="checkbox"/> Family (8) <input type="checkbox"/> Friend (1) <input type="checkbox"/> Word of Mouth (9) <input type="checkbox"/> Baylor Hospital (19) <input type="checkbox"/> Health Plan/Insurance Company (17) <input type="checkbox"/> Emergency Room (7) <input type="checkbox"/> Direct Mail (18) <input type="checkbox"/> 1-800-4-BAYLOR Referral Line (3) <input type="checkbox"/> Website/Internet (13) <input type="checkbox"/> Walk-In (4) <input type="checkbox"/> Newspaper Advertisement (15) <input type="checkbox"/> Radio/TV (16) <input type="checkbox"/> Event (11) <input type="checkbox"/> Location (14) <input type="checkbox"/> Yellow Pages (2) <input type="checkbox"/> Unknown (20)																	

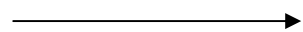
Responsible Party

Guarantor Full Name: Last				First				Middle				(Maiden)					
Address: (Street or Box)						City						State				Zip	
Home Phone # () () ()				Work Phone # () () ()				Cell Phone # () () ()				Drivers License #					
Date of Birth		Age		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security #				Patient Relationship to Guarantor							
Employer														Employer Address			

Insurance Information

Name of Primary Insurance Company						Phone # () ()		Name of Secondary Insurance Company						Phone # () ()	
1. Mailing Address						2. Mailing Address									
City				State		Zip		City				State		Zip	
Policy Number		Group Number		Effective Dates of Policy From: To:		Policy Number		Group Number		Effective Dates of Policy From: To:					
Policy Holder (if other than patient)						Date of Birth		Policy Holder (if other than patient)						Date of Birth	
Social Security #						Relationship to Patient		Social Security #						Relationship to Patient	
Policy Holder's Employer						Work Phone # () ()		Policy Holder's Employer						Work Phone # () ()	
Employer Address															
City				State		Zip		City				State		Zip	

(COMPLETE NEXT PAGE)





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Patient Name: _____

Consent to Treat

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

If patient is a minor:

I consent for _____ to authorize evaluation and treatment for my child named
(Name(s): First & Last)

herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Signature of Patient, Parent, or Legal Guardian

Date

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas (hereinafter "HT") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to HT. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HT, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Signature of Patient, Parent, or Legal Guardian

Date

Patient Name: _____

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Patient Preference Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to *Cardiovascular Consultants of North Texas* to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ I do not wish to disclose any information with anyone.
--

II. How to Contact

I wish to be contacted in the following manner:

Home Telephone:	Work Telephone:	Cell Phone:
<input type="checkbox"/> OK to leave message with detailed information	<input type="checkbox"/> OK to leave message with detailed information	<input type="checkbox"/> OK to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Leave message with call-back number only

<input type="checkbox"/> Written Communication <input type="checkbox"/> OK to mail to my home address _____ _____ _____ <input type="checkbox"/> OK to mail to my work/office address _____ _____ _____ <input type="checkbox"/> OK to fax to this number _____ _____
--

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of Patient or Legal Representative

Date

Patient Name: _____ Patient Identifier: _____



**ACKNOWLEDGMENT OF THE RECEIPT OF
HEALTHTEXAS PROVIDER NETWORK'S (HTPN) NOTICE OF HEALTH
INFORMATION PRACTICES**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. HTPN is furnishing you with the attached notice, which provides information about how HTPN and its physicians¹ may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of HTPN's *Notice of Health Information Practices*.**

(Signature of Patient or Legal Representative)

(Date)

May 20, 2010
(Effective Date of Notice)

¹Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

Patient Name:

Medical Record Number:

Review of Systems

Please check ALL appropriate conditions/ descriptions that apply.

CARDIAC: CHEST PAIN SWEATING PALPITATIONS NEAR BLACKOUTS BLACKOUTS

Vascular: Leg pain with walking Swelling/Site _____

General: Weight gain Weight loss Fever

HEENT: Vision change Hearing loss

Pulmonary: Snoring Blood in Sputum Shortness of breath

Gastrointestinal: Nausea/Vomiting Bleeding Diarrhea Reflux

Genitourinary: Blood in urine Frequent urination

Neurological: Dizziness Memory loss Seizures

Psychiatric: Depression Hallucinations Anxiety

Hematological: Acute anemia Low platelet count

Reproductive: History of oral contraceptives

Endocrine: Goiter Tremors Diabetes Thyroid

Dermatologic: Rash Skin Sores

Musculoskeletal: Joint pain Muscle aches

How many pillows do you sleep with? _____

Past Medical History

Please list past hospitalizations/ surgeries or major illnesses and dates

Chronic Lung Disease Post Menopausal Overweight Renal Failure Other: _____
Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

Please describe:

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

ALLERGIES TO MEDICATIONS

Please Include Reactions to the Medications:

Allergic to Contrast Dye: Yes No

Drug Allergies and Reactions (Ex: Aspirin – gives me a rash):

Primary Care Physician _____

Referring Physician _____

Reason for Visit _____

Pharmacy Name & Number _____

Patient Name:

Medical Record Number:

CARDIAC RISK FACTORS

Please check YES/NO on all conditions that may apply. If marked YES please fill out additional information on the left.

Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No	Current/Former: Type: _____ Year Quit: _____ Years Smoked: _____ Packs per Day: _____
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 Year Diagnosed: _____
History of Elevated Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Cholesterol: _____ Triglycerides: _____ (Good) HDL: _____ (Bad) LDL: _____ Date of last labs: _____
High/Elevated Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Year Diagnosed: _____
Leg pain with Exercise (PVD) <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Description: _____
Family History of Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Adopted <input type="checkbox"/> Unknown <input type="checkbox"/> Mother: Age of onset: _____ Type of heart problem: _____ <input type="checkbox"/> Father: Age of onset: _____ Type of heart problem: _____ Siblings (Please specify brother or sister): Age of onset: ____ Type of heart problem: _____ <input type="checkbox"/> Brother <input type="checkbox"/> Sister Age of onset: ____ Type of heart problem: _____ <input type="checkbox"/> Brother <input type="checkbox"/> Sister Age of onset: ____ Type of heart problem: _____ <input type="checkbox"/> Brother <input type="checkbox"/> Sister Other (Please specify relation): Age of onset: ____ Type of heart problem: _____ Relation: _____ Age of onset: ____ Type of heart problem: _____ Relation: _____
Diet	<input type="checkbox"/> Regular <input type="checkbox"/> Low Fat <input type="checkbox"/> Low Salt <input type="checkbox"/> Diabetic <input type="checkbox"/> Renal <input type="checkbox"/> No added Salt <input type="checkbox"/> Weight loss <input type="checkbox"/> Low Carb <input type="checkbox"/> Vegetarian
Frequency of Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sedentary <input type="checkbox"/> Occasional <input type="checkbox"/> Regular
Alcohol Use <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Social <input type="checkbox"/> Daily
Drug Use/Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Social <input type="checkbox"/> Daily
Caffeine Use <input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____

- | Medication name | dosage | Medication name | dosage |
|-----------------|--------|-----------------|--------|
| 1. _____ | | 8. _____ | |
| 2. _____ | | 9. _____ | |
| 3. _____ | | 10. _____ | |
| 4. _____ | | 11. _____ | |
| 5. _____ | | 12. _____ | |
| 6. _____ | | 13. _____ | |
| 7. _____ | | 14. _____ | |

Name: _____
Last First

DOB: _____
mm/dd/yr



HEALTHTEXAS PROVIDER NETWORK

HealthTexas Provider Network is implementing a systematic method of collecting data on race, ethnicity, and communication needs directly from patients or their caregivers. The purpose of collecting this information is to ensure that all patients receive high-quality care.

We would like for you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

First, do you consider yourself Hispanic/Latino? *Of the following choices, please choose the one that best describes your ethnicity.*

- Yes No Decline

Which category best describes your race? *Of the following choices, please choose the one that best describes your race. Race definitions can be found at the bottom of this page.*

- American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
 Black or African American Multiracial
 White Decline
 Asian (includes Pakistan or Indian origins)

What language do you feel most comfortable speaking with your doctor or nurse? *Of the following choices please choose the one that best fits you.*

- English Tagalog Do not know
 Spanish Hindi Decline
 Vietnamese Italian Other (*please provide*): _____
 Chinese Korean Sign Language or other Auxiliary Aid
or Service

Do you require any assistive devices for a hearing impairment?

- Yes No Decline

Do you require assistive devices for vision impairment?

- Yes No Decline

Race Definitions: American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. Black or African American: A person having origins in any of the black racial groups of Africa. White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Multiracial: A person having more than one or a combination of the above origins