Karing Hearts Cardiology
A proud supporter of Kari's Heart Foundation

Patient Demographics

Patient Information

Last Name: First Name: Middle Initial:

Date of Birth: Social Security Number: Gender ☐Male ☐Female ☐Other

Address: APT/Suite# City: State: Zip:

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Other

Home Phone ( ) Work Phone ( ) Cell Phone ( )

Email Address:

Emergency contact ( ) Relationship:_____

Pharmacy: Address:

Physician Information

Referring Physician: Primary Care Physician:

Insurance

Policy Holder's Name: Policy Holder's Date of Birth

Insurance Company: Insured's ID# Policy Group#

Policy Holders Relationship: Do you have Medicare Coverage? ☐ Yes ☐ No

Is the insurance through Employer ☐Yes ☐No Employer/Company Number:

Deductibles, co-pays, or a percentage of uncovered services for consultations, tests, and any other services under Karing Hearts Cardiology will be collected. Please understand that some services may not be covered by insurance therefore, patients are responsible for uncovered services. While some services may not be covered by Insurance, we are willing to work out payment plans. If payments are not paid at the clinic a bill will be sent to your home address.

I have read and agree to the terms above:

SIGNATURE X_____ Date __/__/____

(Signature of individual or individual's legally Authorized Representative)

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian

☐ Other _____

AUTHORIZATION FOR RELEASE OF PATIENTS INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION TO DPR, TO TEXT MESSAGE (SMS), TO VOICEMAIL/ANSWERING MACHINE OR BY EMAIL

This Authorization grants permission to the Designated Party(ies) named below to: make or confirm appointments; have access to x-ray, laboratory, or test findings: have access to telephone communication, and answering machine messages, as well as other common means of communication; pick up sample medications; be made aware of my diagnosis, prognosis, and treatment plans; and have access to my financial health information. Unless otherwise noted below, this authorization grants Karing Hearts Cardiology permission to leave messages on my answering machine/voicemail/text messages (SMS) and/or contact me by email using my protected health information pertaining to; scheduling or confirming appointments, information related to x-ray, laboratory, or test/procedure findings, information deemed appropriate/necessary by health care provider(s). I understand that by giving Karing Hearts Cardiology my email address, I am granting permission for Karing Hearts Cardiology to contact me through email regarding my PHI.

I understand that message/data rates may apply to messages sent by Karing Hearts Cardiology under my cell phone plan.

I understand that text messages are not a substitute for professional or medical attention.

( ) Please do not leave messages on my answering machine ( ) Please do not contact me by email ( ) Please do not send text messages

I hereby authorize Karing Hearts Cardiology to use/disclose my individually identifiable health information as described above to the parties named below.

I understand that this authorization is voluntary, I understand that once this information is released, it may no longer be protected by federal privacy regulations.

Patient Name: _____ DOB: __/____/_____

Contact Name: _____ **Relationship to patient**: _____

Address: _____ **Phone:** _____

Contact Name: _____ **Relationship to patient**: _____

Address: _____ **Phone:** _____

Please read the three statements below carefully before signing this document

1. **Understand that I may revoke this Authorization at any time by notifying Karing Hearts Cardiology in writing; However, if I do revoke the Authorization, it will not have any effect on any actions taken in reliance upon the Authorization by Karing Hearts Cardiology prior to their receipt of the revocation.**
2. I understand that my treatment cannot be conditioned before signing this document.
3. I understand that this Authorization will **expire 1 year from the date executed.**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I have read and agree to the terms above:

SIGNATURE X_____ Date __/__/____

(Signature of individual or individual's legally Authorized Representative)

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian

☐ Other _____

Karing Hearts Cardiology: Patient History **Name: _____**

Date of Birth: ___/___/____

Medicine Allergies: Check/Write ALL that Apply

Shrimp ☐ **Shellfish** ☐ **Iodine** ☐ **Contact Dye** ☐ **Penicillin** ☐ **Other:**_____

Cardiac History: Please Check/Write ALL that Apply

CAD		
Heart Catheterization ☐ Year _____	Angioplasty/Stent/Rotoblator ☐ Year _____	Bypass Surgery ☐ Year_____
Arrhythmia		
Atrial Fibrillation ☐ Year Diagnosed _____	Elective Cardioversion ☐ (Shock to Restore Normal Rhythm) Year _____	Pacemaker/Defibrillator ☐ Year _____
PVD		
TIA (Mini Stroke) ☐ Year _____	Surgery/Stent to Arteries in Neck ☐ (Carotids)/Legs/Kidney Year _____	Aneurysm ☐ Year _____
Valvular		
Valve Disease ☐ Year _____	Heart Valve Surgery ☐ Year _____	Which Valve? _____

Cardiac Risk Factors: Check/Write ALL that Apply

Do you use tobacco(cigarettes/smokeless)? Yes ☐ No ☐ Former ☐

How Many Packs per Day_____For how many years_____ Date that you Quit? _____

Diabetes Mellitus Yes ☐ No ☐ Juvenile ☐ Adult ☐ How long _____

High Blood Pressure? Yes ☐ No ☐

High Cholesterol? Yes ☐ No ☐

Has Anyone in your Immediate Family had Heart Disease before age 60? If so, who? _____

Social Family History: Check/Write ALL that Apply

Number of Children:_____Sons_____Daughters

Alcohol Consumption: Rarely ☐ Occasionally ☐ Often ☐ Never ☐

Occupation:_____Disabled ☐ Retired ☐ Still Working ☐

Over →

Name: _____

Past Medical History: Check/Write ALL that Apply

Have you ever been diagnosed with any of the following?

☐ Abdominal aortic aneurysm	☐ Coronary artery disease	☐ Occlusive disease artery
☐ Acute Coronary Syndrome	☐ Coronary artery embolism	☐ Osteoporosis
☐ Allergies	☐ Coronary artery stenosis	☐ Peptic ulcer disease
☐ Anemia/Iron deficient	☐ Coronary artery thrombosis	☐ Pulmonary valve disorder
☐ Aneurysm of coronary vessels	☐ Depression	☐ PVD/Peripheral vascular disease
☐ Angina/chest pain	☐ Diabetes	☐ Renal disease
☐ Anxiety	☐ Elevated lipids	☐ Seizure disorder
☐ Arthritis	☐ GERD -Gastroesophageal Reflux Disease	☐ Stroke
☐ Asthma	☐ Headache, migraine	☐ Thyroid disease
☐ Blood clots	☐ Heart murmur	☐ Valvular disease
☐ Cancer	☐ Hepatitis/liver disease	☐ Other…
☐ Cardiac arrhythmia	☐ Hypertension	☐ Other…
☐ Cardiovascular disease	☐ Irritable bowel disease	
☐ Carotid artery stenosis	☐ Ischemic heart disease	
☐ COPD	☐ Myocardial infarction	

Surgical History

Have you ever had the following surgeries?

☐ Angioplasty	☐ Hernia Repair
☐ Appendectomy	☐ Hip replacement
☐ Back surgery	☐ Hysterectomy
☐ Blood transfusion	☐ ICD insertion
☐ CABG – Open heart surgery	☐ Mastectomy
☐ Cardiac pacemaker	☐ Joint surgery
☐ Carpal tunnel release	☐ Thyroidectomy
☐ Cataract extraction	☐ Tonsillectomy
☐ Cholecystectomy	☐ Breast Augmentation
☐ Dialysis	☐ Other…

Karing Hearts Cardiology

Vascular Risk Assessment

Name:_____Date of Birth:_____**Date: _____**

Circle **"Yes"** or **"No"** to determine if a vascular exam will help better access your leg health.

At the end of the day:

1. Are your legs swollen, painful, red or warm to the touch?	Yes	No
2. Do your legs feel heavy, tired, restless or achy?	Yes	No
3. Do you get pains from prolonged sitting or standing?	Yes	No

Other Symptoms:

4. Have you had a blood clot in a vein that caused inflammation, pain or irritation?	Yes	No
5. Do you have varicose veins, ropey or bulgy veins (raised above? the skin surface) in the legs?	Yes	No
6. Do you suffer from tingling, numbness, burning or cramping in the legs or feet?	Yes	No
7. Do you have skin discoloration on your lower legs?	Yes	No
8. Do you have hard to heal ulcers or sores on your lower legs?	Yes	No
9. Do you have a family history of blood clots?	Yes	No
10. Have you had a DVT (Deep Vein Thrombosis) in the past?	Yes	No
11. If female, have you had one or more children?	Yes	No
12. Throughout the day do you have to stop, rest or elevate your legs to complete daily tasks?	Yes	No
13. Have you tried leg elevation, oral pain medication or compression stockings to help relieve symptoms?	Yes	No

Please indicate any activities of daily living that are affected by your condition (ex. Working, driving, shopping etc.): _____

Clinical Notes: _____

_____

Diagnostic Recommended: **Yes** ☐ **No** ☐

Provider Signature: _____

Over →

Please list below all medications you are currently taking:

Medication Name	Dosage	Frequency Taken
1.		
2.		
3.		
4.		
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Karing Hearts Cardiology, PC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: ___/____/____
SSN:_____

Address: _____ Phone: _(_____)_____

I hereby authorize: ***Karing Hearts Cardiology, PC*** to ☐acquire/ ☐send the

medical records of _____
Patient name

☐ From/☐ To:_____
Name/Address of person /Organization which request to be made.

For the following purpose: **Cardiac Care**

For treatment dates:

Type of Access Requested: **Records**

Description of Medical Records to be used / disclosed

☐ Cardiac Studies / EKG ☐ Other _____

☐ Operative /procedure

☐ Radiology

_____
Initials

I acknowledge, and hereby consent to such, that the released information may contain psychiatric, alcohol, drug abuse, HIV testing, HIV results, or AIDS information.

This authorization will remain in effect for one year from the date of signature.

I understand that I may revoke this authorization at any time by notifying in writing the Medical Record Department of Karing Hearts Cardiology, PC. Such notice will not have any effect on any actions already made prior to this authorization. I understand that my healthcare, payment for my healthcare, enrollment or eligibility of benefits will not be affected if I do not sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy rules. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this Authorization for Release of Medical Information.

___/____/_____ _____ _____
Date Signature of Patient/Parent/Conservator/Guardian Relationship to Patient

Office Use Faxed On _____

Records receive on _____