

**Naresh V. Mody, MD Biju T. Mathews, MD Rene Celis, MD**

*Comprehensive Cardiology Care ~ Board Certified in Cardiology*

605 N. Washington Ave, Suite 100, Titusville, FL 32796

Tele (321) 383-7600 Fax (321) 383-8111

Re: Upcoming Appointment

Dear Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You have an appointment scheduled with Dr. Mody, Dr. Mathews or Dr. Celis on

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time \_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete the enclosed paperwork and return to our office 3-4 days prior to your appointment**. We need to enter this information into our electronic record in advance in order to minimize your wait time in seeing the physician on your first visit. If we do not have your completed new patient paperwork prior to your appointment, it will be necessary to reschedule you.

Please bring your insurance card. Any deductible, copay or coinsurance is payable at the time of each visit. If your insurance requires a pre-authorization or a referral from your primary physician, you must make sure that this is done prior to your appointment. Typically, HMO’s require a referral.

**In order to properly evaluate and treat you, we will need a complete list of medications you are currently taking. Additionally, we require you BRING YOUR MEDICATION BOTTLES with you to verify and identify where you are filling and who is prescribing your current medications on your behalf. Understand that your appointment will be rescheduled if you fail to bring your medications and list.**

If you have any further questions please contact the office at 321-383-7600. We look forward to seeing you soon.

**If you are a minor (under the age of 18), a parent must accompany you and sign a consent for you to be treated**.



**FLORIDA CARDIOVASCULAR ASSOCIATION 605 N. WASHINGTON AVE. STE. 100 TITUSVILLE, FL 32796**

**NARESH V. MODY, M.D. BIJU T. MATHEWS, M.D. RENE CELIS, M.D.**

**TEL (321) 383-7600 FAX (321) 383-8111**

**PATIENT DEMOGRAPHIC INFORMATION (IF A MINOR UNDER AGE 18 PARENT MUST SIGN ON CONSENTS)**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_MI:\_\_\_\_\_\_\_Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**State\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_**

**2ND ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(2nd address if applicable)**

**State \_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred contact number\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: Male \_\_\_\_ Female\_\_\_\_\_\_Driver License#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nearest Relative or Friend to contact in case of emergency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY**

**Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed**

**How many children do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who currently lives with you at home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you exercise? Yes \_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_ if yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any dietary restrictions: Yes \_\_\_\_\_\_\_\_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_ If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list to whom the office may speak with regarding your medical care and treatment, also their phone #’s.**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name / phone number Name /phone number**

**I authorize the office to release PHI to above noted individuals noted above**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient or Parent (if minor) Signature Date**

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**Release Record**

**Medicare Benefits to Provider, Physicians and Patient**

I certify that the information given by me in applying for payment under file XVIII of the social security act is correct. I authorize any holder of medical information or other information or other information about me to release to the social security administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare for payment.

**Authorization for Medical and Diagnostic** **Treatment**

I, the undersigned, as the patient of his/her authorized representative, hereby authorize Florida Cardiovascular Association their employees and agents, to treat the condition(s) which appear indicated by the admission complaints and findings. I will be informed of the modes of treatment, risks involved, and the nature of the procedure(s) to be done. No guarantee has been made that my present condition will be cured.

**Release of Medical Records Release of medical records and medical information**

I, the undersigned, as the patient or his/her authorized representative, hereby authorize Florida Cardiovascular Association and /or it representative(s) to release to my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim.

**Assignment of Insurance and Financial Responsibility Assignment of insurance and financial responsibility**

I hereby authorize payment to Florida Cardiovascular Association for benefits otherwise payable to me, including major medical insurance. I understand that I am financially responsible for all charges incurred during this treatment program, whether or not paid by said insurance, It is my responsibility to pay any deductible(s) amount or any other balance not paid by my insurance in 45 days.

**I Agree…**

I agree to pay Florida Cardiovascular Association any monies owed if a referral form authorizing the visit is not brought in at the time of the visit or within 10 days after the visit. I agree to authorize the release of my health information to other physicians and/or specialist if needed for treatment or further medical necessity

**The Undersigned …**

The undersigned has read and understands the above statements and willingly and voluntarily agrees, whether as the patient or his/her authorized representative, to release Orlando Medical Group or its employees, from any and all liability which may arise from this action, whether or not foreseen at present.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or if Minor Parent Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or if Minor Parent Signature

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**Financial Policy**

**Health Insurance Plans-**You agree to provide your current health insurance information at your first appointment and at any time there is a change in your health insurance plan. This is necessary in order to obtain necessary authorizations, referrals and to check eligibility as well as to avoid denial of claims.

**Laboratory**

It is a requirement of your insurance plan to know where your Laboratory work will be sent. Please select the lab corresponding to your insurance plan.

Quest Diagnostics: \_\_\_ Lab Corp \_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participating HMO, PPO, POS and Indemnity plans:**

• Your deductible is your responsibility according to your insurance plan.

• Your copay / coinsurance is your responsibility according to your insurance plan.

• If you have any questions regarding this please call your insurance company prior to your visit or procedure. Any other questions call Florida Cardiovascular Association 321-383-7600

• Please understand that it is the patient’s responsibility to understand the rules and regulations of their policy. If we are not a participating physician, you may be responsible for charges incurred.

• If applicable, please obtain required referral/authorization from your Primary Care Physician prior to your visit. You may be rescheduled if no authorization has been obtained.

• Please call your insurance company prior to your visit to make sure our Physicians participate with your insurance plan and that your services are a “covered” benefit.

• If your insurance requires a co-pay, this will be collected at the time of your appointment. We will file your insurance claims as a courtesy. If your claims have not been paid within a timely manner, you may receive our billing statement notifying you of these circumstances. At the time you will be asked to call you insurance carrier to check claim status first and then call our Billing Department at 321-383-7600 to assist you.

**Missed Appointments**

If more than one appointment within a calendar year is missed without notifying the office within 24 hours to cancel, a $35.00 non-refundable fee will be charged to your account for any subsequent appointments and must be paid prior to re-scheduling. If a new patient misses an appointment, a $35 fee will be charged prior to re-scheduling and will be applied to a co-pay amount if the appointment is honored, however if it is missed this fee will be forfeited. Only true emergencies, such as a documented for example; hospitalization, or auto accident will be considered in order to waive any of the noted fees. If a pattern of missed appointments occurs you may be discharged from the practice.

**Self-Pay and Non-Participating Insurance:**

If you have a high deductible plan you are responsible for paying for all services at the time they are rendered until such time that this deductible has been met.

If you have an HSA (health savings account), we do not bill them. Please request a debit card if available through your HSA account. You may also submit a copy of your explanation of benefits to your HSA plan administrator for direct reimbursement. We are unable to verify how much is currently in your HSA account therefore unless you have debit card to use at the time of service you will be expected to pay any copayments or coinsurance amounts owed.

• Any and all past due to patient’s balances will be collected before your appointment.

• Returned checks are subject to a $25.00 service fee.

• Fees for medical records and forms vary, please call 321-383-7600 for pricing.

• This Financial Policy Statement must be signed prior to any treatment.

\*\*\*\***Delinquent accounts beyond 90 days without agreed upon payment arrangements are subject to discharge from the practice and a $25 reinstatement fee once the debt is reconciled**. \*\*\*

I have read the Financial Policy. I understand and agree to this Financial Policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Parent if Minor Date

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Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**Primary:**

Insurance Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: Self: \_\_\_\_\_\_\_\_\_\_\_Spouse: \_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary:**

Insurance Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: Self: \_\_\_\_\_\_\_\_\_\_\_Spouse: \_\_\_\_\_\_\_\_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRING PHYSICIAN**

Did another Physician refer you? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

If yes, please complete the following information so we can send a report to your referring physician.

Referring Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have a primary physician OTHER than your referring physician, please complete the following information so we can send a report to your primary care physician.

Primary Physician Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­Date:\_\_\_\_\_\_\_\_\_\_

**PATIENT MEDICAL HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CONDITION (circle one )** | **YES** | **NO** | **ONSET DATE** | **NOTES explain details who treated** |
| Arrhythmias or Palpitations |  |  |  |  |
| Cancer |  |  |  |  |
| Clot in leg DVT or lung PE |  |  |  |  |
| Coronary Artery Disease |  |  |  |  |
| Diabetes or Endocrine disorder |  |  |  |  |
| Elevated Cholesterol |  |  |  |  |
| Eye, Ear, Nose or Throat |  |  |  |  |
| Genitourinary, prostate, kidney stones, uterus, bladder |  |  |  |  |
| GERD or Stomach Ulcers |  |  |  |  |
| Heart Attack |  |  |  |  |
| Hypertension |  |  |  |  |
| Mental Illness |  |  |  |  |
| Peripheral vascular disease |  |  |  |  |
| Pulmonary or Lung Disease |  |  |  |  |
| Renal or Kidney Disease |  |  |  |  |
| Rheumatology, arthritis gout |  |  |  |  |
| Skin disorder |  |  |  |  |
| Stroke |  |  |  |  |
| Thyroid Disease |  |  |  |  |
| Valvular Heart Disease |  |  |  |  |
| Varicose veins |  |  |  |  |

**Prior Testing**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Cardiac Testing or Surgery** | **Yes** | **No** | **Date** | **Notes (Where was test performed?)** |
| Ablation |  |  |  |  |
| Angioplasty/stent |  |  |  |  |
| Arterial Ultrasound |  |  |  |  |
| Bypass or Valve surgery |  |  |  |  |
| Cardiac Catheterization |  |  |  |  |
| Cardioversion |  |  |  |  |
| Carotid Surgery |  |  |  |  |
| Carotid Ultrasound |  |  |  |  |
| Echocardiogram |  |  |  |  |
| Event Monitor |  |  |  |  |
| Holter Monitor |  |  |  |  |
| Cardiac surgeries: |  |  |  |  |
| Other surgeries: |  |  |  |  |
| Pacemaker/Defibrillator |  |  |  |  |
| Peripheral angioplasty stents |  |  |  |  |
| Stress Echo |  |  |  |  |
| Stress Test |  |  |  |  |
| Venous Ultrasound |  |  |  |  |

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Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **Surgeries** | **Year** | **Surgeon** |
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**Family History**

|  |  |  |
| --- | --- | --- |
| Relationship | Significant health Problems | If deceased age at death |
| Father |  |  |
| Mother |  |  |
| Sibling (check one)  Brother ( ) Sister ( ) |  |  |
| Sibling Brother ( ) Sister ( ) |  |  |
| Grandmother | Maternal: Paternal: | Mat. Pat. |
| Grandfather | Maternal: Paternal: | Mat. Pat. |

**Social History**

**Occupation now or prior to retirement?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Exercise: type of exercise\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diet: Restrictions or type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tobacco History**

Have you ever smoked cigarettes? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

If yes, how much do you currently smoke per day? 1/2 pack\_\_\_\_\_\_ 1 pack\_\_\_\_\_ More than 1 pack\_\_\_\_\_\_\_

If you have previously smoked, and quit what age were you when you quit? \_\_\_\_\_\_\_\_\_\_\_\_

How many years did you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much did you smoke pack per day\_\_\_\_\_\_\_\_\_\_

**Substance History**

Have you had significant exposure to Pesticides \_\_\_\_\_\_\_

Do you drink Alcohol? Yes \_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_ Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of alcoholic beverages day \_\_\_\_\_\_\_\_\_week \_\_\_\_\_\_\_\_\_month \_\_\_\_\_\_\_\_\_\_\_ socially \_\_\_\_\_\_\_\_\_

Caffeine per day: number of cups per day tea\_\_\_\_\_\_\_\_\_ coffee\_\_\_\_\_\_\_\_\_\_ soft drinks\_\_\_\_\_\_\_\_\_\_\_

Have you or do you take street drugs? Yes \_\_\_\_\_\_\_\_\_\_\_\_No \_\_\_\_\_\_\_\_\_\_\_If yes, which kind?

( ) Marijuana ( ) Cocaine ( ) Heroin ( ) PCP ( ) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**End of Life Wishes**

Do you have a Living Will? Y\_\_\_\_\_ N \_\_\_\_\_\_\_Health Care Surrogate? Y\_\_\_\_\_\_ N\_\_\_\_\_\_\_

Power of Attorney? Y\_\_\_\_\_\_ N\_\_\_\_\_\_

Do Not Rescusitate: Y\_\_\_\_\_ N\_\_\_\_\_\_ If you have answered yes, **please provide a copy of the documents for your chart ☺**

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Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle all that apply**

|  |  |  |  |
| --- | --- | --- | --- |
| **Recent or Current Symptoms** | **Yes** | **No** | **Explanation in detail** |
| **Cardiovascular** |  |  |  |
| Chest Pain or Angina |  |  |  |
| Irregular Heart rhythm palpitation |  |  |  |
| Swelling of the feet, ankles or hands |  |  |  |
| **Constitutional** |  |  |  |
| Good general health lately |  |  |  |
| Recent weight changes |  |  |  |
| Fatigue |  |  |  |
| Frequent nausea or vomiting |  |  |  |
| Difficulty sleeping |  |  |  |
| **Hematology/Lymphatic/oncology** |  |  |  |
| Easy Bruising |  |  |  |
| Frequent bleeding |  |  |  |
| **Musculoskeletal** |  |  |  |
| Leg muscle stiffness or pain |  |  |  |
| Weakness of leg muscles |  |  |  |
| Difficulty in walking |  |  |  |
| **Neurological** |  |  |  |
| Headaches |  |  |  |
| Numbness or tingling sensation |  |  |  |
| Weakness or paralysis |  |  |  |
| Convulsions or seizures |  |  |  |
| Loss or blurring of vision |  |  |  |
| Blackouts or dizziness |  |  |  |
| Memory loss or confusion |  |  |  |
| **Respiratory** |  |  |  |
| Shortness of breath |  |  |  |
| **Skin Problems** |  |  |  |
| Rash, eczema, |  |  |  |
| **Genitourinary** |  |  |  |
| Burning or urgency |  |  |  |
| **Psychiatry** |  |  |  |
| Recent or chronic stress |  |  |  |

**What is the primary reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**CURRENT MEDICATIONS**

Where do you get your prescriptions filled? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Strength** | **Frequency** | **Prescribed by** |
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**Allergies**

Have you ever had an allergic reaction to any medication? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_

If yes, please list below any medication or substance and the reaction.

|  |  |
| --- | --- |
| **Medication or substance** | **Reaction** |
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Dr. Naresh Mody, M.D., Dr. Biju Mathews, M.D., Dr. Rene Celis, M.D.

**Notice of HIPAA Regulations and Consent Form**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for **FLORIDA CARDIOVASCULAR ASSOCIATION** to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

(**FLORIDA CARDIOVASCULAR’S** Notice of Privacy Policies and Practice provides a more complete description of such uses and disclosures)

I have the right to review the Notice of Privacy Practices and Policies prior to signing this consent. **FLORIDA** **CARDIOVASCULAR ASSOCIATION** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to FLORIDA **CARDIOVASCULAR ASSOCIATION** Privacy Officer at 605 N. Washington Ave. Ste. 100 Titusville, FL 32796. With this consent, Florida Cardiovascular Association may call my home, other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out clinical care, including laboratory results among others.

With this consent, **FLORIDA CARDIOVASCULAR ASSOCIATION** may mail to my home or other alternative location any

***ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TPO, SUCH AS APPOINTMENT REMINDER CARDS AND PATIENT STATEMENTS***.

With this consent, **FLORIDA CARDIOVASCULAR ASSOCIATION**, may text my cell phone any items that assist the practice in carrying out TPO, such as appointment reminders. I have the right to request that **FLORIDA** **CARDIOVASCULAR ASSOCIATION** restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **FLORIDA CARDIOVASCULAR ASSOCIATION’s** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **FLORIDA CARDIOVASCULAR** **ASSOCIATION** may decline to provide treatment to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Date Patient’s printed name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian’s printed name if applicable

**605 N. Washington Ave., Suite 100, Titusville, Florida 32796 Telephone: 321-383-7600 fax: 321-383-8111**

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**FLORIDA CARDIOVASCULAR ASSOCIATION, PA**

**ETHNICITY / RACE (SELECT ONE)**

\_\_\_\_\_\_HISPANIC: A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other

Spanish culture or origin.

\_\_\_\_\_\_NON-HISPANIC Any possible options not covered in the above category.

\_\_\_\_\_\_UNKNOWN A person who cannot or refuses to declare ethnicity.

\_\_\_\_\_\_WHITE A person having origins in or who identifies with any

Of the original Caucasian peoples of Europe, North Africa, or the Middle East.

\_\_\_\_\_\_BLACK A person having origins in or who identifies with any of the black racial groups of Africa

\_\_\_\_\_\_NATIVE AMERICAL/ESKIMO/ALEUT

A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

\_\_\_\_\_\_ASIAN/PACIFIC ISLANDER

A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

\_\_\_\_\_OTHER Any possible options not covered in the above categories. Includes patients who cite more than one race.

\_\_\_\_\_UNKNOWN A person who cannot or refuses to declare race.

**LANGUAGE**

PREFERRED LANGUAGE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CONSENT FOR MEDICAL TREATMENT**

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_the parent and legal guardian of**

**(printed parent or guardian name)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( minor patient )**

**(printed patient/minor name)**

**authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.D.,**

**(printed physician name)**

**A physician at Florida Cardiovascular Association to examine, evaluate and treat the above named patient.**

**Parent or guardian must accompany the minor patient to each visit to discuss plan of care, any further treatment or testing necessary and provide any additional consent needed for continued care.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(signature of parent or guardian) Date**