Cardiac Electrophysiology of Alabama Nada B. Memon, MD, FACC, FHRS

♦ 701 University Blvd., E., Suite 809, Tuscaloosa, AL 35401 ♦ Phone: (205) 759-6921 ♦ Fax: (205) 759-6922

	Date: _____ Age: _____					
	Race (circle one)				**Ethnicity (circle one)**	
	AM	Amer. Indian/Alaska Native	AS	Asian	HL	Hispanic or Latino
	B	Black or African American	W	White	NHL	Not Hispanic or Latino
	NH	Native Hawaiian/Pacific Island	H	Hispanic		
Patient Identification	UNK	Unknown				

LAST NAME: _____ FIRST NAME_____ MIDDLE INIT.:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (Home) _____ (Cell) _____ (Work) _____

Sex: _____ Marital Status:_____ Birthdate: ___/___/___ Spiritual beliefs: _____

Retired: Y / N Employed: Y / N Employer: _____ Phone No.: _____

Social Security No.: _____ Driver's License No.: _____ E-mail: _____

Preferred language:_____ If interpreter, name of interpreter: _____

If interpreter used, name of interpreter: _____

Next of kin/spouse: _____Spouse's Employer: _____

Address: _____Phone #: _____

Person to notify in case of emergency: _____ Relationship to patient: _____

Address of person to notify in case of emergency: _____

Emergency phone notification (other than your number): _____

If patient is a minor, we must have the following information:

Person responsible for account: _____ Relationship to patient: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (Home) _____ (Cell) _____ (Work) _____

Sex: _____ Race: _____ Marital Status: _____ Birthdate: ___/___/____

Retired: Y / N Employed: Y / N Employer: _____ Phone No.: _____

Social Security No.: _____ Driver's License No.: _____

Spouse's Name: _____ Employer: _____ Phone: _____

INSURANCE POLICY INFORMATION:

Insurance company (primary): _____

Name of policy holder: _____ Birthdate of policy holder: _____

Employer of policy holder: _____ Contract/Group: _____

Relationship of patient to policy holder: _____

Insurance company (secondary): _____

Name of policy holder: _____ Birthdate of policy holder: _____

Employer of policy holder: _____ Contract/Group: _____

Relationship of patient to policy holder: _____

REFERRED BY: _____

CONSENT FOR TREATMENT: I consent to necessary treatment, including drugs, medicine, procedures, x-rays, lab tests and/or other studies that may be used by the physician, the nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION: I understand that my information may be given to the insurance company with whom I have coverage, agencies which may be assisting with payment for my care, billing agencies, agencies responsible for reviewing payments and/or quality of care, and other governmental agencies. I give permission for release of this information.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Cardiac Electrophysiology of Alabama of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges of Cardiac Electrophysiology of Alabama for these services. I understand that I am financially responsible to Cardiac Electrophysiology of Alabama for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT: For services furnished by Cardiac Electrophysiology of Alabama, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services, I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fees.

SIGNATURE: _____ DATE: _____

CARDIAC ELECTROPHYSIOLOGY OF ALABAMA
Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Name of Practice: CARDIAC ELECTROPHYSIOLOGY OF ALABAMA

Patient Name: _____

Social Security Number: _____ **Date of Birth:**_____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

1. Name of Personal Representative_____
   Address/Phone: _____
   Relationship to patient:☐ Spouse ☐ Parent(s) ☐Child ☐ Other _____

2. Name of Personal Representative_____
   Address/Phone: _____
   Relationship to patient:☐ Spouse ☐ Parent(s) ☐Child ☐ Other _____

3. Name of Personal Representative_____
   Address/Phone: _____
   Relationship to patient:☐ Spouse ☐ Parent(s) ☐Child ☐ Other _____

4. Name of Personal Representative_____
   Address/Phone: _____
   Relationship to patient:☐ Spouse ☐ Parent(s) ☐Child ☐ Other _____

- **Description of information to be disclosed**: I authorize the practice to disclose all of my protected health information to my designated personal representative, including but not limited to, past and current medical information, billing information, appointment scheduling, prescriptions, etc.
- **Expirations or termination of authorization**: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- **Right to revoke or terminate**: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

CARDIAC ELECTROPHYSIOLOGY OF ALABAMA
ATTN: Privacy Manager
701 University Blvd., East, Suite 809
Tuscaloosa, AL 35401

Redisclosure: We have no control over the person(s) you have listed as your personal r presentative. Therefore, your protected health information disclosed under this authorization, will no longer be protect d by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Secure Communication •• Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email as your preferred method of communication if this is of concern to you.

_____ _____
Patient Signature Date

Copies of signed authorizations are available upon request.

CARDIAC ELECTROPHYSIOLOGY OF ALABAMA

ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from CARDIAC ELECTROPHYSIOLOGY OF ALABAMA. You agree that all records concerning your care within CARDIAC ELECTROPHYSIOLOGY OF ALABAMA shall remain the property of CARDIAC ELECTROPHYSIOLOGY OF ALABAMA.

You understand and agree that such information is used for:

(1) Your treatment - the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient.

(2) Payment for your services - billing, claims management, medical data processing, reimbursement and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account.

(3) Routine healthcare operations - including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of CARDIAC ELECTROPHYSIOLOGY OF ALABAMA; and

(4) Medical research and educational purposes - The office may disclose protected health information to researchers when the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of protected health information.

You acknowledge that you have been provided with a CARDIAC ELECTROPHYSIOLOGY OF ALABAMA Notice of Health Information Practices that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand that CARDIAC ELECTROPHYSIOLOGY OF ALABAMA reserves the right to change the Notice and that CARDIAC ELECTROPHYSIOLOGY OF ALABAMA will provide you with a revised Notice when you come to CARDIAC ELECTROPHYSIOLOGY OF ALABAMA.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: _____
CARDIAC ELECTROPHYSIOLOGY OF ALABAMA: __ Agree _ _ Not Agree _N/A

Patient Signature: _____ Date: _____

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Patient identification

PATIENT (ADULT) HEALTH HISTORY

DATE: _____

Health Maintenance:

Month & Year of last flu vaccine: _____

Year of last pneumovax (pneumonia vaccine), if applicable: _____

Have you had the shingles vaccine? _____ Yes _____ No

Date of last mammogram: _____ Have you ever had an abnormal mammogram? _____ Yes _____ No

Date of last breast exam: _____

Date of last pap smear: _____ Have you ever had an abnormal pap spear? _____ Yes _____ No

Date of last colonoscopy: _____

Date of last Fecal Occult Blood Testing: _____

Heart Health:

Have you had a 2-D Echocardiogram? Date: _____ Physician: _____

Have you had a stress test? Date: _____ Physician: _____

Have you ever worn a holter or event monitor? Date: _____ Physician: _____

Have you ever had a GI (gastrointestinal bleed)? _____ Yes _____ No

Date of most recent bloodwork: _____ Physician: _____

FOR OFFICE USE ONLY

VITALS: HT _____ WT _____ TEMP _____ PULSE _____ RESP _____ O2 SAT _____

BP _____ / _____ POSITION: __STANDING __SITTING LOCATION: __ARM __OTHER_____

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NEW PATIENT (ADULT) HEALTH HISTORY

TODAY'S DATE: _____

Patient identification

Reason for today's visit: _____

Preferred pharmacy for prescriptions:

_____

PAST MEDICAL HISTORY: (Please check any condition(s) that you have currently or have ever had in the past.)

Cardiovascular

- o Abdominal aortic aneurysm
- o Ablation
- o Anemia
- o Angina
- o Aortic stenosis
- o Atrial fibrillation
- o Blood clots
- o Carotid stenosis
- o Complications after cardiac procedures (specify):
  _____
  _____
  _____
  _____
  _____
  _____
  _____
- o Congestive Heart Failure
- o Coronary artery bypass surgery (CABG)
- o Coronary artery disease
- o Coronary artery stents
- o Defibrillator (ICD)
- o DVT(Deep Vein thrombosis)
- o Endocarditis
- o EP study
- o Fainting
- o Heart attack/MI
- o High blood pressure
- o High cholesterol
- o Hypertrophic obstructive cardiomyopathy (HOCM)
- o Irregular heart beat
- o Mini-strokes
- o Mitochondrial disease
- o Near syncope
- o Pacemaker placement
- o Palpitations
- o PE (Pulmonary embolism)
- o Peripheral vascular disease or stents
- o Skipped beats
- o Stroke
- o Syncope
- o TIA(Transient Ischemic Attack)
- o Valve disease

Derm

- o Abscesses
- o Melanoma
- o Psoriasis
- o Skin cancer (specify)_____
  _____

Endocrine

- o Diabetes, on insulin
- o Diabetes, on pills
- o Diabetes, type 1
- o Diabetes, type 2
- o Diabetic neuropathy
- o Gout
- o High blood sugar
- o Hyperthyroidism
- o Hypothyroidism
- o Thyroid problems

GI

- o Cirrhosis
- o Colon cancer
- o Crohn's Disease
- o Diverticulosis
- o GERD (reflux)
- o GI bleeding
- o Hiatal hernia
- o Irritable Bowel Syndrome
- o Liver disease
- o Pancreatitis
- o Peptic Ulcer Disease
- o Stomach ulcer
- o Ulcerative Colitis

GU

Male

- o BPH (Benign prostatic hypertrophy)
- o Blood in urine
- o Epididymitis
- o Inguinal hernia
- o Prostate cancer
- o Prostatitis

Female

- o Blood in urine
- o Dysmenorrhea

HEENT

- o Glaucoma
- o Hearing deficit
- o Vision deficit

Infections

- o Hepatitis
- o HIV/AIDS
- o Syphilis
- o Tuberculosis/TB

Musculoskeletal

- o Arthritis
- o Rotator cuff tear

Neuro/Psych

- o ADHD
- o Alcohol abuse
- o Alzheimer's disease
- o Anxiety
- o Autism
- o Bipolar disorder
- o Brain cancer
- o Dementia
- o Depression
- o Eating Disorder
- o Fibromyalgia
- o Headaches
- o Migraines
- o Parkinsons disease
- o Schizophrenia
- o Seizures
- o Substance abuse

Renal

- o Dialysis
- o Fistula/Location (specifiy)
  _____
- o Peritoneal
- o Renal cancer
- o Renal failure or insufficiency

Respiratory

- o Asthma
- o COPD
- o CPAP use
- o Emphysema
- o Lung cancer
- o Oxygen use
- o Sleep apnea

Cancer (specify)

- o Type: _____
  _____
  _____
- o Port location: _____
  _____
  _____
- o Chemotherapy:
  Dates:_____
  Type:_____
  _____
  _____
- o Radiation:
  Location:_____
  _____
  _____

Other

- o _____
- o _____
- o _____
- o _____
- o _____
- o _____

FOR WOMEN:

- o Last menstrual cycle?
  _____
- o Age at menopause?
  _____
- ○ Do you desire to get pregnant?_____
- o Birth control use? Y / N

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NEW PATIENT (ADULT) HEALTH HISTORY

TODAY'S DATE: _____

Patient identification

CURRENT MEDICATIONS (prescriptions AND over-the-counter/herbals)

Medication	Dose	Frequency	Who prescribed this medication?

Drug Allergies (please list your reaction to each drug): _____

_____

Food/latex/other allergies: _____

Chemotherapy: □ Yes/No **Radiation: □ Yes/No** **Steroids: □ Yes/No**

HOSPITALIZATIONS / SURGERIES / INJURIES:

Year	Name of illness/operation/injury

SPECIALISTS: What specialists do you see? (for example: cardiologist, internist, nephrologist, etc.)

Name of Doctor/Practice	Specialty	Condition for which they treat you

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TODAY'S DATE: _____

Patient identification

FAMILY HISTORY: (Please check if any of your blood relatives have had any of the following:)

Heart problems:
- ○ Atrial Fibrillation
- ○ Congestive heart failure
- ○ Coronary disease
- ○ Electrophysiology study/Ablation
- ○ High cholesterol
- ○ High blood pressure
- ○ Implantable cardiac defibrillator (ICD)
- ○ Pacemaker
- ○ Valve disease
- ○ Wolff-Parkinson-White Syndrome (WPW)

Genetic history:
- ○ Family history of known genetic condition
- ○ Family history of mitochondrial disease
- ○ Family history of sudden cardiac/unexplained death

- ○ Alcoholism
- ○ Asthma
- ○ Atherosclerosis
- ○ Autoimmune disease
- ○ Blood disorder
- ○ Dementia
- ○ Depression
- ○ Diabetes mellitus
- ○ Drug abuse
- ○ Hearing problems

- ○ Hepatitis B
- ○ Kidney disease
- ○ Mental illness
- ○ Obesity
- ○ Rheumatoid disease
- ○ Stroke
- ○ Thyroid disease
- ○ Tuberculosis
- ○ Vision problems
- ○ Other: _____

List all family members and ages:

Relation	Current age or "D" if deceased	Health Problems/Cause of Death
Mother		
Father		
Siblings:		
Children:		

HEALTH HABITS:

	Use daily	Use weekly	Use rarely	Do Not Use	Have used in past, but not now
Alcohol					
Caffeine					
Drugs					
Tobacco					
Herbal supplements					
Other					

Exercise (type and frequency): _____

Diet preferences or restrictions (e.g., gluten-free, vegan, etc.): _____

Spiritual beliefs/preferences: _____

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NEW PATIENT (ADULT) HEALTH HISTORY

TODAY'S DATE: _____

Patient identification

Please check all of the symptoms that you are currently experiencing or have had in the last 6 months.

CONSTITUTIONAL	o Appetite change o Excessive sweating o Fatigue	o Fever o Night sweats	o Weight gain ____ lbs o Weight loss ____ lbs
EYES	o Blurred vision o Wear glasses or contacts o Double vision	o Eye irritation o Eye pain	o Spots in vision o Vision loss
EARS, NOSE, MOUTH, THROAT	o Ear pain o Hearing loss o Ringing in ears o Facial pain o Runny nose	o Nasal obstruction o Nose bleeds o Post-nasal drainage o Bleeding gums	o Dental pain o Mouth lesions o Hoarseness o Sore throat
CARDIOVASCULAR	o Chest pain o Decreased exercise tolerance o Difficulty breathing with exertion	o Difficulty breathing when lying flat o Sleep on more than 1 pillow o Palpitations/irregular heartbeat	o Fainting/passing out o Leg pain with walking o Leg ulcers o Swollen feet/ankles
RESPIRATORY	o Cough o Sputum (phlegm) production o Coughing up blood	o Shortness of breath o Chest pain with deep breathing	o Wheezing o Snoring o Sleep apnea
GASTROINTESTINAL	o Abdominal pain o Bloating o Food intolerance (explain): _____	o Nausea o Vomiting o Trouble swallowing o Reflux/heartburn	o Change in bowel habits o Constipation o Diarrhea o Black stools o Bloody stools
GENITOURINARY	o Change in urinary stream o Pain with urinating o Blood in urine o Incontinence o Awakening at night to urinate	o Frequent urination	o Post-menopausal o Frequent UTIs
MUSCULOSKELETAL	o Back pain o Joint pain o Joint swelling	o Limited range of motion o Muscle aches o Muscle weakness	o Stiffness
INTEGUMENTARY	o Lesions	o Rash	o Breast masses o Breast skin changes
NEUROLOGIC	o Abnormal gait o Weakness of a particular body part (not overall weakness) o Headache	o Incoordination o Memory problems o Numbness o Seizures	o Slurred speech o Tremor o Dizziness or vertigo
PSYCHIATRIC	o Anxiety o Decreased concentration	o Irritability o Panic attacks	o Sleep disturbances o Sadness/tearfulness
ENDOCRINE	o Increased thirst o Increased appetite	o Urinating frequently and large amount	o Hot-natured o Cold-natured o Abnormal menstrual pattern
HEMATOLOGIC/LYMPHATIC	o Easy bruising o Easy bleeding	o Recurrent infections o Swollen lymph nodes	
ALLERGIC/IMMUNOLOGIC	o Eczema	o Seasonal allergies	o Hives

Last revision: July 3, 2014