CARDIOVASCULAR ASSOCIATES, P.C.
HEART, CHEST AND VASCULAR SURGERY

MICHAEL E. DAMRICH, M.D., F.A.C.S. • CARL MALTESE, M.D., F.A.C.S. • RONALD B. O'GORMAN, M.D., F.A.C.S.
WILLIAM R. HIGGS, M.D., F.A.C.S. • DIMITRIS K. KYRIAZIS, M.D., F.A.C.S. • DAVID H. MULL, M.D., F.A.C.S.

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HIPPA FORM

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of **treatment, payment** and **health care operations**. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however, if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment: _____

You may communicate confidential information to me, including invoices for services, to the following address and/or phone

Numbers:_____

_____ _____
Individual Signature Date

As a personal representative, I have authority to act
For the individual because I am the individual's

1901 SPRINGHILL AVENUE
MOBILE, ALABAMA 36607
(251) 300-2240

188 HOSPITAL DRIVE
SUITE 103
FAIRHOPE, ALABAMA 36532
(251) 928-0707

1-800-336-1045
cardiovasculardocs.com

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Patient History Form

Name: _____ **Birth date:** _____

Chief Complaint: What is the main reason for your visit today? _____

History of Present Illness	
Location of Problem: Chest Arm Leg Abdomen Back Other:	Is there anything else occurring at the same time? Yes No Explain _____ Swelling Nausea Fever Chest Pain Other:
On a scale of 1-10, 10 being most severe, which number describes the problem: 1 2 3 4 5 6 7 8 9 10	Is the problem constant or variable? Dull then sharp Very sharp then leaves Constant Other:
How long have you experienced this complaint? _____	Does the problem interfere with your normal functions? Yes No Please Explain: _____
Does anything help or make the problem worse? Moving around Standing up Lying on Side Walking more than 2 blocks Other: _____	How long does the problem last? 30 minutes 1 hour It's always there Other: _____

Past Family Medical & Social History

	Past History	Family History		Past History	Family History
Heart Disease			History of Bleeding		
Kidney Disease			Seizures		
Stroke			Respiratory/Lung Disease		
Hypertension			Diabetes		
Cancer			Tuberculosis		

List any personal past illnesses and/or surgeries & when they occurred: _____

_____

Smoke: Yes No Number of Packs a day _____ How long have you smoked? _____
Are you a former smoker? Yes No Number of Packs a day ____ How long did you smoke? ____
Are you on a special diet Yes No If yes, explain: _____
Do you routinely exercise? Yes No How often? _____
Do you have any allergies? Yes No Please list _____
Are you taking any blood thinners? Yes No What kind? _____
If you are a diabetic, what medications are you taking? _____

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Name: _____

Review of Systems

Constitution Symptoms:			**Integumentary**		
Fever	Yes	No	Skin Rash	Yes	No
Chills	Yes	No	Boils	Yes	No
Headache	Yes	No	Persistent Itch	Yes	No
Other			Other		
Eyes			**Musculoskeletial**		
Blurred Vision	Yes	No	Joint Pain	Yes	No
Double Vision	Yes	No	Neck Pain	Yes	No
Pain	Yes	No	Back Pain	Yes	No
Other			Other		
Allergic/Immunologic			**Ear/Nose/Throat/Mouth**		
Hay Fever	Yes	No	Ear Infection	Yes	No
Drug Allergies	Yes	No	Sore Throat	Yes	No
List:			Sinus Problems	Yes	No
			Other		
Neurological			**Genitourinary**		
Tremors	Yes	No	Urinary Retention	Yes	No
Dizzy Spells	Yes	No	Painful Urination	Yes	No
Numbness	Yes	No	Urinary Frequency	Yes	No
Other			Other		
Gastrointestinal			**Respiratory**		
Abdominal Pain	Yes	No	Wheezing	Yes	No
Nausea/Vomiting	Yes	No	Frequent Cough	Yes	No
Heartburn	Yes	No	Shortness of Breath	Yes	No
Other			Other		
Cardiovascular			**Hemotalogic/Lymphatic**		
Chest Pain	Yes	No	Swollen glands	Yes	No
Varicose Veins	Yes	No	Blood Clotting	Yes	No
High Blood Pressure	Yes	No	Other		
Other					

Physician Reviewed: _____ Date: _____

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MEDICATION RECORD

PATIENT_____ **DOB**_____

DATE_____ **CHART#**_____

ALLERGIES_____

DATE	CURRENT MEDICATION	UPDATES

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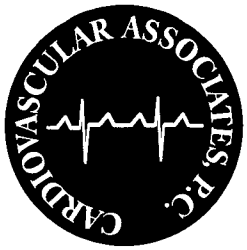

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New Patient Information

Patient Chart#: _____ Date of Birth: _____

Patient Name: _____ Sex: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Spouse Name: _____ DOB: _____

Alternate #: _____ Spouse Employer: _____

Employer: _____ Spouse Employer Phone #: _____

Employer Phone #: _____ Emergency Contact Besides Spouse: _____

Referring Physician: _____ Emergency Contact Telephone #: _____

Cardiologist: _____ Family Physician: _____

Insurance Information

Primary	Secondary
Insurance: _____	Insurance: _____
Insured Name: _____	Insured Name: _____
DOB: _____	DOB: _____
Contract Number: _____	Contract Number: _____
Group Number: _____	Group Number: _____

My office copay is $ _____. All copays are due for today's office visit.

Permission for release of Medical Records, Assignment of Benefits, and Acceptance of Financial Responsibility.

I authorize direct payment to Cardiovascular Associates, the basic and/or major medical benefits, but not to exceed the balance due of the physician's regular charges for these services. I understand that I am responsible for all charges incurred. I agree to pay any and all fees left unpaid by my insurance company. I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of individual rights.

Patient's Signature: _____ **Date:** _____

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