



The Dallas Heart Group

How did you hear about us?

Referral from Doctor (which?) _____ Web Site / Search Engine (which?) _____
 Friend / Relative (who?) _____ Radio / TV (what station?) _____
 Newspaper / Magazine (which?) _____ Newsletter _____
 Seminar / Event (what?) _____ Direct Mail Piece _____

PATIENT PROFILE

PATIENT'S NAME

Last: _____ First: _____ MI: _____ Sex: _____ DOB: _____ Age: _____
 Street Address: _____ City: _____ ST: _____ Zip: _____
 Day Phone: (_____) Home Phone: (_____)
 SS # _____ Occupation: _____
 Employer: _____ Employers Phone: (_____)
PRIMARY/FAMILY PHYSICIAN (PCP): _____ **REFERRING PHYSICIAN:** _____



SPOUSE'S / PARENT'S NAME

Last: _____ First: _____ MI: _____ Relationship: _____
 Street Address: _____ City: _____ ST: _____ Zip: _____
 Home Phone: (_____) Cell Phone: (_____)
 SS # _____ Occupation: _____
 Employer: _____ Employer's Phone: (_____)



EMERGENCY CONTACT

Last: _____ First: _____ Relationship: _____ Phone: _____
 Street Address: _____ City: _____ ST: _____ Zip: _____

NEAREST RELATIVE NOT LIVING WITH YOU

Last: _____ First: _____ Relationship: _____ Phone: _____
 Street Address: _____ City: _____ ST: _____ Zip: _____



PRIMARY INSURANCE CARRIER:

HMO POS PPO

Street Address: _____ City: _____ ST: _____ Zip: _____
 Insured's Name: _____ SS: _____ DOB: _____
 Relationship to Patient: _____ Policy # _____ Group # _____

SECONDARY INSURANCE CARRIER:

HMO POS PPO

Street Address: _____ City: _____ ST: _____ Zip: _____
 Insured's Name: _____ SS: _____ DOB: _____
 Relationship to Patient: _____ Policy # _____ Group # _____

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www.dallasheartgroup.com

THE DALLAS HEART GROUP



CREDIT POLICY

All services rendered by this association are charged directly to the patient. As a courtesy we will file your primary and secondary insurance claims at no charge and credit their payments to your account.

Unless we are contracted with your insurance carrier as a participating provider to accept what they approve, your deductible or the percentage not covered by the carrier is due at the time of service. Managed care co-pays are due at the time of service.

If you do not have insurance, payment arrangements must be made prior to service. If you first saw the physician in the hospital payment arrangements must be made immediately after hospital discharge.

Payment of your charges is ultimately your responsibility and you as the patient agree to comply with our policy.

SIGNATURE _____ DATE _____

The Dallas Heart Group

CONSENT OF PROFESSIONAL SERVICES/INFORMATION RELEASE/ASSIGNMENT OF BENEFITS

I consent to treatment/services necessary for the care of my present medical condition.

I authorize holder of medical or other information about me to release any information needed to determine benefits.

I hereby assign, transfer and set over to The Dallas Heart Group my assignment of benefits for reimbursement of services rendered.

I hereby acknowledge that I have been presented with a copy of the The Dallas Heart Group Notice of Privacy Practices.

I authorize release of my medical records to myself, if requested.

This consent/authorization/assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for any charges not paid by said insurance carrier(s).

SIGNATURE _____ DATE _____

INSURED'S SIGNATURE _____ DATE _____

THE DALLAS HEART GROUP



SIGNATURE ON FILE (Medicare Patients Only)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Dallas Heart Group for any services furnished me by the association. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated on item 9d of the HCFA-1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, The Dallas Heart Group agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT’S NAME

PATIENT’S SIGNATURE

PATIENT’S MEDICARE NUMBER

DATE

MEDICARE-MEDIGAP AUTHORIZATION (For Medicare Patients Only)

I request that payment of authorized Medigap (Medicare Supplement Insurance Carrier) benefits be made to The Dallas Heart Group for any services furnished me by this provider. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE: _____ **DATE:** _____

THE DALLAS HEART GROUP



DISCLOSURE OF MEDICAL/FINANCIAL INFORMATION TO YOUR FRIENDS AND/OR FAMILY MEMBERS

Patient Name: _____ **SSN:** _____
(ID purposes only)

In our effort to adhere to HIPAA guidelines, Dallas Heart Group (DHG), needs your authorization to release medical/financial information connected with your care. Please complete the information below so that we may release any necessary information to your family member(s) or friends. Please check the appropriate box if you do NOT wish this information to be released.

Please DO NOT release this information.

I, the undersigned, hereby authorize DHG to disclose information from my medical or financial record to the following family member(s) or friends:

Name: _____ Relationship to me: _____

Contact Information: _____

Type of Information that DHG can provide to them: Medical Financial Both

Name: _____ Relationship to me: _____

Contact Information: _____

Type of Information that DHG can provide to them: Medical Financial Both

This authorization is given freely with the understanding that:

1. I may revoke this authorization at any time, but not retroactively.
2. The facility, its employees, officers and physicians are hereby released from any legal responsibility of liability for disclosure of the information I authorized previously.

Signature of Patient

Today's Date

Witness Printed Name

Today's Date

Signature of Witness

THE DALLAS HEART GROUP



PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION VIA PHONE, FAX OR EMAIL

Patient Name: _____

Soc Sec #: _____

Purpose of Request: I authorize DHG to disclose/provide health information at any of the phone numbers or addresses listed below. I understand that it will be my responsibility to notify DHG of any change in these numbers. By signing below, I understand that DHG is authorized to leave a message if I cannot be contacted directly so I can receive information in a timely manner.

List, in order of priority, which number we can call to contact you and/or leave a message:

Email _____ (Complete only if you wish to be contacted in this manner)

Fax # _____ (Complete only if you wish to be contacted in this manner)

Phone # _____ home work cell other (circle which is appropriate)

Phone # _____ home work cell other (circle which is appropriate)

Phone # _____ home work cell other (circle which is appropriate)

I do NOT want DHG to leave me a message. I want to be contacted directly at

By checking this box, I acknowledge that it may be difficult for DHG staff to reach me during normal business hours, which may result in multiple phone calls.

Description of information to be disclosed - I authorize DHG to disclose the following protected health information about me to the numbers or addresses indicated above: Lab results, results of exams/tests, appointment reminders, procedures and other healthcare services. I understand that this is meant as a means of enhancing communication with my healthcare provider and DHG. By signing below, I understand that this authorization is valid for one (1) year and I will be asked to renew this disclosure at the end of the one (1) year period.

Patient Signature _____

Date _____

POLICY FOR MEDICATION AT DALLAS HEART GROUP

So that we can provide the most effective treatment to our patients, we have outlined below our policy for patients regarding medications. Please read carefully and we ask that you follow these guidelines.

- Please take medication(s) properly as prescribed by your physician. If you have questions or are having any possible side effects, please contact our office at 972.566.7733.
- Please bring a list of your current medications and dosages (or bring your medication bottles) to each of your scheduled appointments. Be sure to include medication(s) prescribed by physicians other than Dallas Heart Group.
- For refills, contact your pharmacist directly. Be sure to give them at least 24 hours notice before you run out of your medication. That will give them sufficient time to contact us if they have questions about your medication(s).
- We are unable to refill any prescriptions after normal working hours (this includes the 'on call' evening and weekend physicians).
- Sample medications that may be provided are intended to get patients started on a new prescription to be sure the patient can tolerate the medication. So that we have sufficient samples on hand, we cannot provide patients with samples on an on-going basis. We ask that patients fill their prescriptions when their sample supply is gone.

THE DALLAS HEART GROUP



New Patient Health Questionnaire

Date: ___/___/___

Patient: _____

Gender: M F

Date of birth: ___/___/___; Age: ___; Occupation: _____

Referring Doctor: _____

Please INDICATE all the reasons for your visit.

1. Chest pain () at rest () with exertion
2. Shortness of Breath () at rest () with exertion
3. Palpitations / irregular heart rate
4. Racing heart
5. Swelling legs
6. Dizziness / Fainting
7. Hypertension
8. Heart failure
9. Pre surgical evaluation
10. Establish new cardiologist

H1. PRIOR HEART DISEASE AND TESTING?

YES: NO (Next Section)

Heart murmur / valve prolapse NO YES: YEAR; _____

Rheumatic / Scarlet fever NO YES: YEAR; _____

Angina / Chest pain NO YES: YEAR; _____

Heart attack. NO YES: YEAR; _____ Location: _____

Heart Cath/ Angioplasty /Stent NO YES: YEAR; _____ Location: _____

Bypass surgery NO YES: YEAR; _____ Location: _____

Pacemaker NO YES: YEAR; _____ Location: _____

Defibrillator (AICD) NO YES: YEAR; _____ Location: _____

Heart failure NO YES: YEAR; _____

Stress test (treadmill) NO YES: YEAR; _____ Location: _____

Echo / Ultrasound NO YES: YEAR; _____ Location: _____

Calcium Scoring NO YES: YEAR; _____ Location: _____

Nuclear Thallium PET scan NO YES: YEAR; _____ Location: _____

Carotid ultrasound NO YES: YEAR; _____ Location: _____

CT Angiogram NO YES: YEAR; _____ Location: _____

Holter (24hr monitor). NO YES: YEAR; _____ Location: _____

H2. RISK FACTORS FOR HEART DISEASE:

High cholesterol NO YES: YEAR; ___: TC ___ LDL ___ HDL ___ TG ___

High blood pressure NO YES: YEAR; _____

Diabetes NO YES: YEAR; _____

Female menopause NO YES: YEAR; _____ Hormones Y / N

Current smoker NO YES: _____

Previous smoker NO YES: _____ QUIT: YEAR; _____

Phen/Fen weight loss medicine NO YES: YEAR; _____

H3. BLOOD VESSEL DISEASES

Carotid disease or endarterectomy NO YES: YEAR; _____

Stroke or TIA (ministroke) NO YES: YEAR; _____

Aortic aneurysm NO YES: YEAR; _____ Surgical Repair YEAR; _____

Numbness or tingling of legs NO YES: YEAR; _____

Leg cramps while walking. NO YES: YEAR; _____

Venous thrombosis (leg clots) NO YES: YEAR; _____

Pulmonary embolism (lung clots) ... NO YES: YEAR; _____

MEDICATIONS:

Please list all prescription and non-prescription medicines including vitamins and aspirin.

	NAME	DOSE/STRENGTH	FREQUENCY
Example	Lasix	40 mg.	2 in am / 1 in pm
1.	_____	_____	_____/_____
2.	_____	_____	_____/_____
3.	_____	_____	_____/_____
4.	_____	_____	_____/_____
5.	_____	_____	_____/_____
6.	_____	_____	_____/_____
7.	_____	_____	_____/_____
8.	_____	_____	_____/_____

H4. DO YOU HAVE ANY ALLERGIES TO MEDICINES? NO (next section) YES

Please list all medications to which you have an allergy or adverse response and list the reaction (e.g. penicillin-arm rash)

	Medication	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Are you allergic to iodine, shrimp, or shellfish? NO : YES

Have you received X-ray contrast (myleogram, IVP, CT Scan)? NO : YES

If Yes, did you have any reaction to the contrast? NO : YES

H5. PAST SURGICAL HISTORY (OPERATIONS) NO : YES

Do not relist the cardiac operations already listed.

example	appendectomy	YEAR; 95	Location: Medical City
1.	_____	YEAR; _____	Location: _____
2.	_____	YEAR; _____	Location: _____
3.	_____	YEAR; _____	Location: _____

H6. MEDICAL HISTORY:

1. hepatitis/jaundice NO YEAR; _____
2. asthma NO YEAR; _____
3. peptic ulcer NO YEAR; _____
4. _____

FAMILY HISTORY

Please indicate with an "X" all those immediate family members with the following conditions.

	Father	Mother	Brother 1	Brother 2	Sister 1	Sister 2	Children
1.) Angina	_____	_____	_____	_____	_____	_____	_____
2.) Heart Attack	_____	_____	_____	_____	_____	_____	_____
3.) Angioplasty / Stent	_____	_____	_____	_____	_____	_____	_____
4.) Heart Bypass	_____	_____	_____	_____	_____	_____	_____
5.) Other Heart Surgery	_____	_____	_____	_____	_____	_____	_____
6.) Heart Failure	_____	_____	_____	_____	_____	_____	_____
7.) Stroke	_____	_____	_____	_____	_____	_____	_____
8.) Heart Valve Problem	_____	_____	_____	_____	_____	_____	_____
9.) Congenital Heart Disease	_____	_____	_____	_____	_____	_____	_____
10.) Hypertension	_____	_____	_____	_____	_____	_____	_____
11.) Abnormal Cholesterol / Triglyceride	_____	_____	_____	_____	_____	_____	_____
12.) Diabetes Mellitus	_____	_____	_____	_____	_____	_____	_____
13.) Abdominal Aortic Aneurysm	_____	_____	_____	_____	_____	_____	_____
14.) Pacemaker / AICD	_____	_____	_____	_____	_____	_____	_____
15.) Sudden Death	_____	_____	_____	_____	_____	_____	_____

Father's age at death, if deceased _____

Mother's age at death, if deceased _____

REVIEW OF SYSTEMS: Please circle any and all conditions that you have

GENERAL

Cancer: list site: _____

If yes, Chemotherapy? Y / N

ENDOCRINE

Low thyroid

Pre-diabetes / high blood sugar

EYES

Glaucoma

Cataracts? Y / N

If Yes, Removed? Y / N

LUNG/BREATHING

Asthma

Bronchitis

Emphysema

Snoring / Sleep apnea / CPAP

INFECTIONS

AIDS/HIV

NEUROLOGICAL

Loss of consciousness

Seizures / epilepsy

Headaches / Migraines

ABDOMEN

Hiatus hernia

Reflux disease

Ulcer disease

KIDNEY / BLADDER

Dialysis

Kidney stones

Prostate problems

MUSCLE/JOINT

Arthritis

Chronic back pain

BLOOD

Have you ever taken:

Coumadin Y / N

Warfarin Y / N

Clotting problems

Bleeding problems

Leukemia

Anemia

PSYCHIATRIC

Depression

Bipolar disorder

Anxiety

Panic attacks

Other Conditions?

THE DALLAS HEART GROUP



SOCIAL HISTORY

Marital Status: Married Separated Divorced Widowed Single

Number of Children: _____ With whom do you live? _____

Family Physician: _____

Your other Physicians: 1) _____

2) _____

Are you retired? Yes No

What is your occupation? _____ Retired N/A

How stressful is your job? Very Moderately Mildly Not N/A

Do you take your prescribed medications regularly?

1. Always 2. Most of the time 3. I frequently skip doses

Have you previously smoked?

1. Never
2. Yes, I quit YEAR _____ # of packs/day _____ # of years smoking _____
3. Currently smoking _____ # of packs/day _____
Cigars Pipe Chew tobacco _____ times / day

Do you drink alcohol?

1. Never 2. No, but I quit YEAR: _____
3. Yes, _____ glasses/week of _____ wine beer liquor

Do you take illicit drugs or abuse prescription medications:

1. Never 2. No, but I used to 3. Yes DETAILS: _____

Do you drink caffeine? No Yes: (circle all that apply) Coffee Tea Soft drinks _____ Drinks/ day

How many times/week do you exercise? _____ **How many hrs/session?** _____

What type of exercise do you do: (circle all that apply)

Walking Sports Golf Treadmill
Cycling Weight Lifting Dancing Elliptical
Swimming Aerobics Running Other

Diet: American Heart Step I Atkins Diabetic South Beach
Mainly Red Meat Mainly White Meat Vegetarian Low Sodium
Low fat, Low Cholesterol None of the above

I have provided the above medical history and verify that it is accurate and complete:

Patient signature _____ Date: _____

I have reviewed the above information with the patient: _____ RN, PA, ACNP

Patient Health History has been reviewed by _____ on _____
(Physician signature) (date)