CARDIOVASCULAR GROUP

Account #: _____

PATIENT DEMOGRAPHICS

LAST NAME	FIRST NAME	M.I.

MAILING ADDRESS	CITY	STATE	ZIP CODE

LAST 4 DIGITS OF SS#	SEX	DATE OF BIRTH (MM/DD/YYYY)
X X X - X X -	❑ Male ❑ Female	

HOME PHONE	WORK PHONE	CELL PHONE

MARITAL STATUS	E-MAIL ADDRESS	PREFERRED LANGUAGE
❑ M ❑ S ❑ D ❑ W		

RACE	ETHNICITY	COMMUNICATION PREFERENCE
❑ Black ❑ White ❑ Asian ❑ Other	❑ Hispanic ❑ Non-Hispanic	❑ Phone ❑ Mail ❑ Email ❑ Patient Portal

PRIMARY CARE PHYSICIAN	REFFERING PHYSICIAN

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP TO PATIENT	CONTACT NUMBER

INSURANCE INFORMATION

PRIMARY	SECONDARY

PERSON RESPONSIBLE FOR PAYMENT (IF NOT THE PATIENT)	DATE OF BIRTH (MM/DD/YYYY)

INSURED'S EMPLOYER	INSURED'S SOCIAL SECURITY #	RELATIONSHIP OF PATIENT TO INSURED

PATIENT SIGNATURE	DATE

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVER'S LICENSE TO OUR FRONT DESK STAFF

08-13-2019

CARDIOVASCULAR GROUP

ANNUAL CONSENT / AUTHORIZATIONS

PATIENT NAME	DATE OF BIRTH

Consent for Treatment:

- Permission is hereby given for any medical/surgical procedures or office testing, laboratory test, administration of medication, physical test and assessments, or exam as may be deemed necessary by the physician, physician assistant, nurses, technicians or other healthcare professions as medically necessary.
- I understand I have the right to see a physician if I so choose.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

Consent to Release Medical Information to a Spouse, Family Member or Significant Other:

Tell us with whom we may discuss your protected health information:

NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT

☐ I do not authorize any information to be released to anyone other than myself.

I give permission for you to leave medical/appointment information for me via the following sources:

HOME PHONE	CELL PHONE
EMAIL	OTHER PHONE

Financial Responsibility:

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office.

I hereby authorize any insurance benefits to be paid to CardioVascular Group and recognize my responsibility to pay for all non-covered services.

I also authorize the release of any information necessary to process an insurance claim.

I hereby authorize CardioVascular Group, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at CardioVascular Group or payment for the services I received at CardioVascular Group including but not limited to, debt collection purposes.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____

PRINT NAME EMAIL ADDRESS

CARDIOVASCULAR GROUP

NAME: _____

ADVANCE DIRECTIVE ACKNOWLEDGMENT

DOB: _____

As a competent adult, you have the right to refuse any medical or surgical treatment for yourself for any reason. The best way for you to be in control of your medical treatment is to record your preferences in advance. You can make legally valid decisions about future medical treatments through what is commonly known as an Advance Directive. Listed below are examples of Advance Directives.

1. Living Will: A written document executed by the patient directing that should the patient have a terminal condition, life-sustaining procedures would be withheld or withdrawn.

2. Durable Power of Attorney for Health Care (DPAHC): An Advance Directive in which an individual name some else (the agent or "proxy") to make healthcare decisions in the event the individual becomes unable to make those decisions for him/herself. The DPAHC can also include instructions about specific choices to be made.

3. Directive for Final Health Care: A combination of the Living Will and the Durable Power of Attorney for Health Care.

Please check one of the following statements:

____ I have provided the office with a copy of my Advance Directive.

____ I have executed an Advance Directive and will provide a copy to the office.

____ I have executed an Advance Directive and will not provide a copy to the office.

____ I have not executed and Advance Directive but would like to obtain additional information about Advance Directives.

____ I have not executed an Advance Directive and do not wish to discuss Advance Directives at this time.

SIGNED: _____ _____

Patient/Patient's Representative **Date**

10-1-2018

CARDIOVASCULAR GROUP

NOTICE OF PRIVACY PRACTICES

CVG Physicians Group, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFROMATION. **PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices takes effect on 11/01/2018 and will remain in effect until we replace or modify it.

OUR COMMITMENT TO YOUR PRIVACY

CVG Physicians Group, LLC (CVG) values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information (PHI) about you and the nursing and physician services or medical treatment provided to you. PHI is information about you including individually identifiable information that can reasonably be used to identity you and which relates to your past, present or future physical or mental health or condition; the provisioning of health care to you; or the payment for that care.

We are required by certain federal and state laws to maintain the privacy of your PHI or ePHI. We are also required by the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to give you this Notice about our privacy practices, our legal duties and your rights concerning PHI. We protect your privacy by taking the following precautions:

- Limiting who may see your PHI.
- Limiting how we may use or disclose your PHI.
- Informing you of our legal duties with respect to your PHI.
- Explaining our privacy policies.
- Adhering to the policies currently in effect.

The terms of this notice apply to all records containing your PHI that are created by our practice. We reserve the right to revise of amend this Notice of Privacy Practices. Any revision or amendment to this Notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

How We May Use and Disclose Your Protected Heath Information (PHI) - CVG may use and disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below without obtaining written authorization from you. In addition, CVG and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to provide treatment, received payment and manage their health care operations.

For Treatment – CVG may use and disclose your PHI in the course of providing, coordinating or managing your medical treatment. This includes sharing or disclosing your PHI to your other health care providers for treatment. For example, we may use your PHI when performing medical procedures. These types of uses and disclosures may take place between physicians, nurses, technicians, students and other health care professionals who provide you health care services or are otherwise involved in your care.

For Payment – CVG may use and disclose PHI about you so the services and items you receive may be billed to and payment may be collected from you, an insurance company or a third-party payer. We may need to give your health plan information about the services or items you received so that your health plan will pay us or reimburse you for the services or items.

For Health Care Operations – CVG may use and disclose PHI about you for health care operations. These uses, and disclosures are necessary to make sure you receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in providing services to you. We may also disclose information to other physicians, nurses, technicians, students, attorneys, consultants, accountants and other health care professionals for review and learning purposes. We may remove information that identifies you from this set of PHI so that others may use it to study health care and health care delivery without learning the names of the specific individuals.

Appointment Reminders – CVG may use and disclose your PHI to contact you and remind you of an appointment at CVG, or to inform you of treatment alternatives or other health related benefits and services that may be of interest to you.

We May Use and Disclose Your PHI in Certain Special Circumstances:

As Required by Law and Law Enforcement – CVG may use or disclose PHI when required to do so by law. CVG may disclose PHI when ordered to do so in a judicial or administrative proceeding, to identify or locate a suspect, fugitive, material witness, or missing person, or for other law enforcement purposes without an authorization from you.

Public Health Risks – CVG may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects problems, or to execute their health oversight or public health functions.

Health Oversight Activities – CVG may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with applicable laws and regulations.

Serious Threats to Health or Safety – CVG may use and disclose PHI to law enforcement personnel or other appropriate persons to prevent or lessen a serious threat to the health or safety of a person or the public. CVG may use and disclose PHI of military personnel and veterans under certain circumstances.

Law Enforcement – CVG may disclose PHI for a law enforcement purpose to a law enforcement official under the following conditions:

- As required by law including laws that require the reporting of certain types of wounds or other physical injuries.
- In response to a warrant, summons, court order, subpoena or similar legal processes.
- To identify or locate a suspect, fugitive, material witness or missing person.
- Requests for such information about an individual who is or is suspected to be a victim of a crime provided the individual agree to such disclosure. In case the individual is incapacitated or under emergency circumstances.
- In good faith that the information constitutes evidence of criminal conduct that occurred on the premises of CVG.
- In the course of an emergency shall disclose PHI to a law enforcement officer if the individual is suspected to be a victim of crime or violence.

Workers' Compensation – CVG may disclose PHI to comply with workers' compensation or other similar laws. These programs provide benefits for work-related injuries or illness without regard to fault.

Research – CVG may use and disclose your PHI for research purposes regardless of the source of funding of the research under the following circumstances:

- With documentation related to approval of a waiver of authorization by an institutional review board or a properly constituted privacy board.
- Acceptance of necessity for the purpose of research and description of the information sought.

Fundraising Activities – CVG will not use or disclose your PHI for fundraising activities.

Deceased Patients – CVG may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a deceased individual, to identify the cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Organ, Eye and Tissue Donation – CVG may release PHI to organ procurement organizations to facilitate organ, eye and tissue donation and transplantation.

Disclosures to you – CVG may disclose your PHI to you or to your personal representative and is required to do so in certain circumstances described in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI.

Disclosures for HIPAA Compliance Investigations. CVG must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the Secretary) when requested by the Secretary in order to investigate our compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Other Uses and Disclosures of PHI for Which Authorization Is Required. Other types of uses and disclosures of your PHI not described above will be made only with your written authorization. For example, your written authorization is required for psychotherapy notes (with limited exceptions), sale of your PHI, and certain marketing communications. You have the right to revoke your authorization in writing. Revocations will only apply to disclosures made after your request to revoke is received.

Regulatory Requirements. CVG is required by law to maintain the privacy of your PHI and to support your rights under HIPAA. You have the following rights regarding your PHI:

- **Notice of Privacy Practices.** CVG must provide individuals with notice of its legal duties and privacy practices with respect to PHI and to abide by the terms described in this Notice and of its privacy policies and to make the new terms applicable to all PHI we maintain. Before CVG makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice as required by the regulation.
- **Restriction Requests.** You may request that CVG restrict the use and disclosure of your PHI. CVG is not required to agree to any restrictions you request, but if CVG does so it will be bound by the restrictions to which it agrees, except in emergency situations. CVG will restrict PHI disclosures to health plan if the PHI disclosure is for payment or health care operations and the PHI pertains to a health care item or service for which you have paid out of pocket in full. However, if the information is needed to receive payment from the insurer for subsequent related services, the restriction no longer applies.

- **Confidential Communications.** You have the right to request that communications of PHI to you from CVG be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, rather than at home address. Your requests must be made in writing and sent to the responsible CVG Department Director. CVG will accommodate your

- **Access to PHI.** You have the right to inspect or receive copies of your PHI contained in a designated record set, including patient medical records and billing records, but not including psychotherapy notes. You must submit your requests in writing to the Privacy Officer at CVG in order to inspect and/or obtain a copy of your PHI. CVG may charge a fee for the costs of copying, mailing, labor or supplies associated with your request. CVG may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. If you seek a review, a licensed health care provider chosen by us will review your request and the denial. The person conducting the review will not be the person who originally denied your request. We shall comply with the outcome of the review.

- **PHI Amendment.** You may request that we amend your PHI if you believe there is a mistake in your PHI or that important information is missing. To request an amendment to your PHI, your request must be made in writing. In addition, you must provide a reason that supports your request. We will generally make a decision regarding your request for amendment no later than 60 days after receipt of your request. However, if we are unable to act on the request within this time, we may extend the time for 30 more days but shall provide you with a written notice of the reason for the delay and the approximate time for completion. If we deny your requested amendment, we will provide you with a written denial. Approved amendments made to your PHI will also be sent to those who need to know. We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing and explain your right to file a written statement of disagreement.

- **Accounting of Disclosures.** You may request, in writing, an accounting of disclosures. Any accounting of disclosures will not include those we made under these conditions: for payment or health care operations, to you or individuals involved in your care, with your authorization, for national security purposes or to correctional institution personnel. To request an accounting of such disclosures, your request must be submitted in writing. Your request must also state a time period, which may not be longer than six (6) years. Your request should also specify the format in which you prefer to receive the accounting, i.e. paper or electronic. We may charge you for the costs of providing the accounting. We will notify you of the costs involved, and you many choose to withdraw or modify your request at that time before any costs are incurred.

- **Breach Notification.** In the case of a breach of unsecured PHI, we will contact you as required by law.

- **Right to a Paper Copy of This Notice.** You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically.

- **Right to File a Complaint.** If you believe your privacy rights have been violated, or if you are dissatisfied with our privacy practices or procedures, you may file a complaint with the U.S. Secretary of the Department of Health and Human Services or with our practice. To file a complaint with our practice, contact the Privacy Officer at CVG. All complaints must be submitted in writing. CVG assures you that filing a complaint will not in any way impact the services we provide to you, nor will there be any retaliatory acts against you.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer at 770-962-0399.

CARDIOVASCULAR GROUP

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read this Privacy Practices notice before you decide whether or not to sign. A copy of this Notice and/or this consent is available upon request. This Privacy Notice provides a description of CVG's treatment, payment activities and health care operations, of the uses and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you consent to CVG's use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Patient Consent: I have been given a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this form, I am giving my consent to CVG's use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient's Name:

_____

Patient's Signature:

_____ Date: _____

Parent/Legal Guardian Name: Relationship to Patient:

_____

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ▫ Individual refused to sign
- ▫ Communication barriers prohibited obtaining the acknowledgment
- ▫ Other (please specify) _____

CARDIOVASCULAR GROUP

Payment Policy

Thank you for choosing Cardiovascular Group as your Cardiology provider. We are committed to providing you with affordable health care of the highest quality. Some of our patients have had questions regarding patient and insurance responsibility for services rendered. We have been advised to develop this payment policy. Read it thoroughly and ask any questions you may have. Please sign in the space provided. A copy will be provided to you upon request.

1. Insurance:

   We participate in most insurance plans, including Medicare. If you are not covered by a plan that we are contracted with or you do not have insurance, a deposit of **$250.00** if you are a New patient and **$100.00** for an established patient visit will be required prior to your appointment. Once you have seen your physician, a final bill amount will be available at checkout. Any overpayment will be credited. If you have a balance, two payment options are available. Firstly, a prompt pay discounted amount and secondly a payment amount if you choose to wait for the bill to be mailed to you. Credit card payment plans are available and can be set up at checkout.

   Should your physician recommend a test for you, the person at checkout will explain the minimum deposit required for a self-paying patient in order to proceed with the test. There are two payment plans available to pay the balance required once the test has been completed, a prompt pay amount or a delayed payment amount. Payment plans are available to pay the balance owed. If you are insured by a plan that we are out of network with or do not have an up-to-date insurance card, we will require the same deposits until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles:

   All co-payments must be paid at time of service. Should you not be able to pay your co-pay at the time of service, we will allow you to be seen once. However, a valid credit card will need to be produced. A charge date for payment of the co-pay will need to be established.

   If you have a high deductible plan you will be required to pay 20% prior to your visit with your Doctor. Please note that provided we have updated insurance information our staff will be able to research if your deductible has been met.

   Should your physician order a test, our office staff will provide you with your responsible deductible amount that will be required prior to the test being performed.

A truly indigent patient, proven by paperwork that he/she has completed at the hospital, will be seen without any charge.

Patients who choose not to abide by our payment process will be seen once and then be provided with a list of other cardiology groups in the area to contact for further care.

We want our patients to be as educated and informed as possible regarding their insurance plan. We understand that these high deductible plans can be confusing to the patient. While the onus is ultimately on the patient to be educated regarding this, we want to help you understand your payment responsibilities. **Please feel free to ask for advice**. We have financial counselors available on request. Failure on our part to collect co-payments and deductibles from patients is illegal.

3. Non-covered services:

   Please be aware that some – and perhaps all – of the services you receive may be not be covered or get denied by insurers. You will be required to pay in full for these services at the time of the visit, should you choose to proceed with the visit or tests ordered.

4. Proof of insurance:

   All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to confirm proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

   Any tests or procedures that are ordered by your physician that require prior authorization will be scheduled in a timely fashion to allow our authorization staff to obtain this. Any testing or procedures deemed urgent by your physician will not be delayed. Once authorization is acquired, any payment that you are personally responsible for will be communicated to you prior to the test or procedure being performed.

5. Claims submission:

   We will submit your claim and assist you in any way reasonably possible to get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not**. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes:

   If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If

your insurance company does not pay your claim within the industry standards time frame, the balance will automatically be billed to you. The same payment plans will be made available to you that is mentioned earlier in this document.

7. Nonpayment:

   If your account has a balance of $500.00 or greater and is 90 days past due and you do not have a payment plan that you are adhering to, unfortunately we will no longer be able to see you as a patient. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. **All accounts that are six months past due will be turned over to external collections.** Should this occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. We will provide you with a list of possible doctors and or practices in the area. During this 30-day period, our physicians will only be able to treat you on an emergency basis.

8. Missed appointments:

   While at this stage, we do not charge for missed appointments, we would appreciate that you respect our time as we respect your healthcare. Please make us aware if you are unable to make your appointment, preferably at least 24 hours prior.

The doctors and staff of CVG are committed to providing you with the highest quality state of the art healthcare at affordable prices. It is our pleasure to be your doctor. Thank you for having the trust to place your health in our hands.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____

Patient name

_____ _____

Signature of patient or responsible party Date

CARDIOVASCULAR GROUP

NEW PATIENT QUESTIONNAIRE

(Encuesta para pacientes nuevos)

Name ***(Nombre)***: _____

Date of Birth ***(Fecha de nacimiento)***: _____

Weight ***(Peso)***: _____ Height ***(Eststura)***: _____

01) Describe in your own words why you need to see a cardiologist.
Describe en sus propias palabras por qué necesita ver a un cardiológo

_____

_____

_____

02) Past medical illness ***(Historia médica pasada)***
Have you ever had any of the following medical problems? If so, when?
¿A sufrido usted de alguno de los siguientes problemas médicos? Si es así, ¿cuando?

Heart attack ***(ataque al Corazón)***	Yes ***(Si)***	No	_____
Stroke ***(apoplejía/derrame cerebral)***	Yes ***(Si)***	No	_____
High blood Pressure ***(presión alta)***	Yes ***(Si)***	No	_____
Caner ***(cáncer)***	Yes ***(Si)***	No	_____
Asthma ***(asma)***	Yes ***(Si)***	No	_____
Diabetes ***(diabetes)***	Yes ***(Si)***	No	_____
Ulcers ***(Úlceras)***	Yes ***(Si)***	No	_____
Vascular Disease ***(enfermedad vascular)***	Yes ***(Si)***	No	_____
Rheumatic Fever ***(fiebre reumática)***	Yes ***(Si)***	No	_____
Mitral Valve Prolapse ***(prolapse de válvula mitral)***	Yes ***(Si)***	No	_____
Hepatitis ***(hepatitis)***	Yes ***(Si)***	No	_____
Thyroid Disease ***(desorden de tiroides)***	Yes ***(Si)***	No	_____
Kidney Disease ***(enfermedad de riñones)***	Yes ***(Si)***	No	_____
Endocarditis ***(endocarditis)***	Yes ***(Si)***	No	_____
Emphysema ***(enfisema)***	Yes ***(Si)***	No	_____
Hiatal Hernia ***(hernia hiatal)***	Yes ***(Si)***	No	_____
Gallbladder Disease ***(enfermedad tie vesícula)***	Yes ***(Si)***	No	_____
Elevated Cholesterol ***(colesterol elevado)***	Yes ***(Si)***	No	_____
Sleep Apnea ***(apnea del sueño)***	Yes ***(Si)***	No	_____
Atrial Fibrillation ***(La fibrilación auricular)***	Yes ***(Si)***	No	_____

03) Past surgical history **(*Historial quirúrgico pasado - cirugías*):**
Please list any surgical procedures along with the date.
Favor de anotar todo procetlimiento quirúrgico (de cirugía) junto con la fecha

_____

_____

_____

04) Have you ever had a cardiac catheterization, angioplasty, stress test, or echocardiogram? If so, when and where?
¿Alguna vez le an sometido un cateterismo cardíaco, angioplastía, prueba de esfuerzo o una ecocardiograma? Si es así, ¿Cuándo y dónde?

_____

_____

05) Please list all medications you are currently taking, dosage (strength) and frequency (number of times per day).
Por favor de anotar todos los medicamentos que usted toma al presente, junto con la dosis (potencia) y la frecuencia (número de veces al dia) que las toma.

_____ _____

_____ _____

_____ _____

_____ _____

06) Please list all over-the-counter medications you are currently taking. (For example: decongestants, diet pills, Aspirin, or antihistamines.) ***Favor de anotar todos los medicamentos sin receta que está tomando al presente. Por ejemplo: descongestionantes, píldoras dietéticas, aspirina o antihistamínicos.***

_____ _____

_____ _____

_____ _____

07) Are you allergic to any medications? If so, please list the medication and the type of reaction.
¿Es usted alérgico a algún medicamento(s)? Si es asi, por favor anotar el medicamento(s) y el tipo de reacción.

_____ _____

_____ _____

08) Have you ever smoked? If so, How many years? How many packs per day? When did you quit?
¿A usted fumado alguna vez? Si es asi, ¿por cuantos años? ¿Cuántos paquetes diarios? ¿Cuándo dejó de fumar?

_____

09) Do you consume alcoholic beverages? If so, how many drinks per day?
¿Consume usted bebidas alcohólicas? Si es así, ¿cuántos tragos al día? ..... Yes **(*Si*)**_____ No

10) Do you consume caffeine? If so, how much?
¿Consume usted cafeína? Si es así, ¿qué cantidad? ..... Yes **(*Si*)**_____ No

11) Have you ever used any recreational drugs? If so, what type?
¿A usado drogas recreativas alguna vez? Si es así, Qué tipo de drogas? ..... Yes (***Si***)_____ No

12) Do you have a family history of heart disease?
If so, please list which family member, type of heart disease and age at the time of diagnosis.
¿Tiene historial de enfermedad cardiaca en su familia?
Si es asi, anote qué miembro de su familia, la edad en que fue diagnosticado, y el tipo de enfermedad del corazón.

_____

_____

13) What is your occupation?
¿Cuál es su ocupación? _____

14) OVERALL SYSTEM REVIEW
REVISION GENERAL DE SU SISTEMA

Please check any of the **symptoms you are experiencing or have had in the last few weeks.**
If none of these symptoms apply to you, please leave this section blank.

General
- ❑ Fever
- ❑ Chills

Eyes
- ❑ Blurred vision
- ❑ Double vision

Heart (new symptoms)
- ❑ Chest pain
- ❑ Palpitations
- ❑ Feeling a fast heartbeat
- ❑ Swelling (legs, feet, hands)
- ❑ Dizziness
- ❑ Passing out

Lung / Breathing
- ❑ New shortness of breath
  - ❑ During activity
  - ❑ At rest
  - ❑ While lying flat

Ears, Nose, Mouth, Throat
- ❑ Hearing loss
- ❑ Nosebleeds

Stomach/Intestines
- ❑ Rectal bleeding
- ❑ Black colored stools

Muscle / Bones
- ❑ Muscle weakness
- ❑ Muscle pain/cramps

Blood
- ❑ Easy Bruising
- ❑ Bleeding

Brain/Nerves
- ❑ Stroke
- ❑ Transient Ischemic Attack (TIA)
- ❑ Memory problems

Peripheral / Vascular
- ❑ Pain in the legs or calves when walking

15) Who is your primary care doctor?
¿Quién es su médico de familia/cabecera**?**_____

16) What pharmacy do you use? Please write the phone number.
¿Qué farmacia utiliza? Por favor escriba el número telefónico de la **farmacia**

_____ , (_____) _____ - _____

17) List any other physicians you see. ***Anote cualquier otro médico que usted vea*** _____

_____ , _____ , _____

18) Have you had any procedures, x-rays, or blood work done recently? If so, name of test and where performed.
¿Le an hecho algún procedimiento, como: radiografias o laboratorios de sangre recientemente? Si es así, indique el nombre del análisis y en dónde fue realizado?

_____

_____ _____

Patient Signature ***(Firma del paciente)*** Date **(*Fecha*)**

Main Office Location

Lawrenceville

755 Walther Road
Lawrenceville, GA 30046
770.962.0399

Satellite Office Locations

Dacula

2108 Teron Trace – Ste 100
Dacula, GA 30019
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Duluth

3855 Pleasant Hill Rd. – Ste 250
Duluth, GA 30096
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Gainesville

535 Jesse Jewell Pkwy – Ste C
Gainesville, GA 30501
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Johns Creek

4365 Johns Creek Pkwy – Ste 450
Suwanee, GA 30024
770.495.2442

Loganville

98 Tara Commons Drive
Loganville, GA 30052
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Snellville

1608 Tree Lane Rd. – Bldg. C
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Suwanee

1120 Peachtree Ind. Blvd. – Ste 209
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Buford

4745 Nelson Brogdon Blvd. – Ste 300
Sugar Hill, GA 30518
770.962.0399

Peachtree Corners

5277 Peachtree Parkway
Peachtree Corners, GA 30092
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