Heart and Vascular Care, Inc.

3970 Deputy Bill Cantrell Memorial Road, Suite 100, Cumming, GA 30040
Phone: 678-513-CARE (2273) • Fax: 678-513-8869 • www.hvcmd.com

Clinical Cardiology • Cardiac Imaging • Diagnostic Catheterization • Interventional Cardiology • Peripheral Vascular • Pacemaker Services • Electrophysiology

PATIENT EVALUATION (PLEASE ANSWER ALL QUESTIONS)

Date: ______________

Name: ______________________________ Referring Physician ______________________________

Reason for Visit ____

Past Medical History (check all that apply)

❑ Coronary Artery Disease ❑ High Cholesterol ❑ Thyroid Disorders ❑ Myocardial Infraction (Heart Attack) ❑ Stroke/TIA ❑ COPD/Lung Disease
❑ Sleep Apnea ❑ Asthma/Allergies ❑ Autoimmune Disorders ❑ Hypertension (High Blood Pressure) ❑ Anemia ❑ Diabetes Mellitus
❑ Heart Burn/Peptic Ulcers/Reflux ❑ Bleeding Disorders ❑ DVT ❑ Pulmonary Embolism ❑ PVD ❑ Kidney Disease ❑ Arthritis
❑ Lumbar Spine / Disk Degeneration ❑ Cancer ❑ HIV/AIDs ❑ Hepatitis ❑ Other ______________________________

List all Surgeries: ____

List all Allergies: ____

List all Medications and Dosage: (Including aspirin and over the counter medications.) ______________________________

____

____

Pharmacy: ____

Adddress: ____

Phone: ______________________ Fax: ______________________

Family History (check all that apply)

	Heart Disease	High Blood Pressure	Stroke	Heart Attack	Cancer	High Cholesterol	Diabetes	Seizures	Pacemaker Treatment	Congenital Defects
Father:										
Mother:										
Brother:										
Sister:										

Social History/Risk Factors

Smoker: ❑ yes ❑ no _______ packs per day, Former Smoker: ❑ yes ❑ no ______ year quit Smokeless Tobacco: ❑ yes ❑ no
Alcohol: ❑ yes ❑ no amount, if applicable ______________________________
Caffeine: ❑ yes ❑ no amount, if applicable ______________________________
Exercise: ❑ yes ❑ no how often: ______________________________

Review of Systems:	Please check all that apply:	Acute (New Problem)	Chronic (Existing Problem)
GENERAL	FEVER		
	UNEXPLAINED WEIGHT LOSS		
CARDIOVASCULAR	CHEST DISCOMFORT		
	SHORTNESS OF BREATH		
	PALPITATIONS		
	EDEMA (SWELLING)		
	PAIN IN ARMS/LEGS		
RESPIRATORY	SNORING		
	COUGHING		
	WHEEZING		
GASTROINTESTIONAL	NAUSEA		
	HEARTBURN		
	BLOOD IN STOOL		
GENITOURINARY	BLOOD IN URINE		
	PAIN WITH URINATION		
MUSCULOSKELETAL	JOINT PAIN		
	MUSCLE PAIN		
NEUROLOGICAL	NUMBNESS/TINGLING		
	POOR BALANCE		
PSYCHOLOGICAL	ANXIETY		
	DEPRESSION		

Annual Consent/Authorizations

Patient Name:________________________________ **Date of Birth:**_____/_____/_____

Consent for Treatment: I consent to the rendering of medical treatment or services as considered necessary and appropriate by the physician, physician assistant, nurse practitioner or designated staff. The consent to receive medical treatment or services includes but is not limited to: initial evaluations, assessment evaluations, electrocardiogram, laboratory services or procedures, medications, patient education, and other services in which the patient will receive. I hereby authorize my physician or designated staff to perform diagnostic studies, as a recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. Diagnostic testing and services may include but is not limited to: echocardiograms, carotid ultrasounds, exercise treadmill test, nuclear stress test, PET scans, vascular and arterial ultrasounds, event monitors and other services recommended by your physician. I am aware that there may be material risks associated with these procedures. If I have any questions or concerns regarding any procedure, I will ask my physician to provide me with additional information.

I understand I have the right to see a physician if I so choose, and have the right to see a physician prior to any prescription drug or device order being carried out by the physician assistant or nurse practitioner.

I give my consent to have the Heart and Vascular Care group obtain my prescription history from external sources. ________**(initials)**

Consent to release Medical Information to a spouse, family member or significant other

I hereby authorize Heart and Vascular Care group to release and/or disclose any information contained in my medical record to the person(s) listed:

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 and appointment information for me via the following source(s):

☐ Phone ☐ Text Message ☐ Email

Financial Responsibility

I understand that it is my 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 Heart and Vascular Care, Inc group and recognize my responsibility to pay for all non-covered services rendered. I also authorize the release of any information necessary to process an insurance claim.

Signature of Patient/Legal Guardian________________________________ Date:_____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned patient or legal authorized representative of the patient acknowledges that he or she personally was offered and/or received a copy of Heart and Vascular Care, Inc. group's "Notice of Privacy Practices" on the date indicated below.

Privacy Practices are also posted in the front office near check-in for your review

Last Name: ______________________________ First Name: ______________________________

Date: _______/_______/_______

Signature of Patient or Legal Guardian: ____

FOR OFFICE USE ONLY

☐ Patient/Representative is unable to sign - Notice of Privacy Practices Provided

☐ Patient/Representative refused to sign - Notice of Privacy Practices Provided

☐ Other ____

Staff Name (Print):___________________________________ Title: __________________

Signature: ____ Date: _____/_____/_____

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