



# Heart and Vascular Care, Inc.

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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: \_\_\_\_\_

Address: \_\_\_\_\_

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  
 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		
GASTROINTESTINAL	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

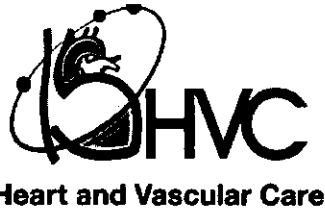
Text Message

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: \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>
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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: \_\_\_\_/\_\_\_\_/\_\_\_\_